This Document can be made available in alternative formats upon request

State of Minnesota

Printed Page No. 239

HOUSE OF REPRESENTATIVES

EIGHTY-SIXTH SESSION

HOUSE FILE NO. 1362

March 5, 2009
Authored by Huntley
The bill was read for the first time and referred to the Committee on Finance
April 24, 2009
Committee Recommendation and Adoption of Report:
To Pass as Amended and re-referred to the Committee on Rules and Legislative Administration
April 24, 2009
Committee Recommendation and Adoption of Report:
To Pass and re-referred to the Committee on Ways and Means
April 25, 2009
Committee Recommendation and Adoption of Report:
To Pass as Amended
Read Second Time

1.1 A bill for an act
1.2 relating to state government; establishing the health and human services
1.3 budget; making changes to licensing; Minnesota family investment program,
1.4 children, and adult supports; child support; the Department of Health and
1.5 health care; health care programs; making technical changes; chemical and
1.6 mental health; continuing care programs; establishing the State-County Results,
1.7 Accountability, and Service Delivery Redesign; public health; health-related
1.8 fees; making forecast adjustments; creating work groups and pilot projects;
1.9 requiring reports; increasing fees; appropriating money to various state agencies
1.10 for health and human services provisions; amending Minnesota Statutes 2008,
1.11 sections 13.465, subdivision 8; 62J.495; 62J.496; 62J.497, subdivisions 1,
1.12 2, by adding subdivisions; 62J.692, subdivision 7; 103I.208, subdivision 2;
1.13 125A.744, subdivision 3; 144.0724, subdivisions 2, 4, 8, by adding subdivisions;
1.14 144.121, subdivisions 1a, 1b; 144.122; 144.1222, subdivision 1a; 144.125,
1.15 subdivision 1; 144.218, subdivision 1; 144.225, subdivision 2; 144.2252;
1.16 144.226, subdivisions 1, 4; 144.72, subdivisions 1, 3; 144.9501, subdivisions
1.17 22b, 26a, by adding subdivisions; 144.9505, subdivisions 1g, 4; 144.9508,
1.18 subdivisions 2, 3, 4; 144.9512, subdivision 2; 144.966, by adding a subdivision;
1.19 144.97, subdivisions 2, 4, 6, by adding subdivisions; 144.98, subdivisions 1,
1.20 2, 3, by adding subdivisions; 144.99, subdivision 1; 144A.073, by adding
1.21 a subdivision; 144A.44, subdivision 2; 144A.46, subdivision 1; 148.108;
1.22 148.6445, by adding a subdivision; 148D.180, subdivisions 1, 2, 3, 5; 148E.180,
1.23 subdivisions 1, 2, 3, 5; 153A.17; 156.015; 157.15, by adding a subdivision;
1.24 157.16; 157.22; 176.011, subdivision 9; 245.4885, subdivision 1; 245A.03, by
1.25 adding a subdivision; 245A.10, subdivisions 2, 3, 4, 5, by adding subdivisions;
1.26 245A.11, subdivision 2a, by adding a subdivision; 245A.16, subdivisions 1,
1.27 3; 245C.03, subdivision 2; 245C.04, subdivisions 1, 3; 245C.05, subdivision
1.28 4; 245C.08, subdivision 2; 245C.10, subdivision 3, by adding subdivisions;
1.29 245C.17, by adding a subdivision; 245C.20; 245C.21, subdivision 1a; 245C.23,
1.30 subdivision 2; 246.50, subdivision 5, by adding subdivisions; 246.51, by
1.31 adding subdivisions; 246.511; 246.52; 246B.01, by adding subdivisions;
1.32 252.46, by adding a subdivision; 252.50, subdivision 1; 254A.02, by adding
1.33 a subdivision; 254A.16, by adding a subdivision; 254B.03, subdivisions 1,
1.34 3, by adding a subdivision; 254B.05, subdivision 1; 254B.09, subdivision
1.35 2; 256.01, subdivision 2b, by adding subdivisions; 256.045, subdivision 3;
1.36 256.476, subdivisions 5, 11; 256.962, subdivisions 2, 6; 256.963, by adding
1.37 a subdivision; 256.969, subdivision 3a; 256.975, subdivision 7; 256.983,
1.38 subdivision 1; 256B.04, subdivision 16; 256B.055, subdivisions 7, 12; 256B.056,
1.39 subdivisions 3, 3b, 3c, by adding a subdivision; 256B.057, subdivisions 3, 9,

2.1 by adding a subdivision; 256B.0575; 256B.0595, subdivisions 1, 2; 256B.06,
2.2 subdivisions 4, 5; 256B.0621, subdivision 2; 256B.0625, subdivisions 3c, 7,
2.3 8, 8a, 9, 13e, 17, 19a, 19c, 26, 41, 47; 256B.0631, subdivision 1; 256B.0641,
2.4 subdivision 3; 256B.0651; 256B.0652; 256B.0653; 256B.0654; 256B.0655,
2.5 subdivisions 1b, 4; 256B.0657, subdivisions 2, 6, 8, by adding a subdivision;
2.6 256B.08, by adding a subdivision; 256B.0911, subdivisions 1, 1a, 3, 3a, 4a, 5, 6,
2.7 7, by adding subdivisions; 256B.0913, subdivision 4; 256B.0915, subdivisions
2.8 3e, 3h, 5, by adding a subdivision; 256B.0916, subdivision 2; 256B.0917,
2.9 by adding a subdivision; 256B.092, subdivision 8a, by adding subdivisions;
2.10 256B.0944, by adding a subdivision; 256B.0945, subdivision 4; 256B.0947,
2.11 subdivision 1; 256B.15, subdivisions 1, 1a, 1h, 2, by adding subdivisions;
2.12 256B.37, subdivisions 1, 5; 256B.437, subdivision 6; 256B.441, subdivisions
2.13 48, 55, by adding subdivisions; 256B.49, subdivisions 12, 13, 14, 17, by adding
2.14 subdivisions; 256B.501, subdivision 4a; 256B.5011, subdivision 2; 256B.5012,
2.15 by adding a subdivision; 256B.5013, subdivision 1; 256B.69, subdivisions 5a,
2.16 5c, 5f; 256B.76, subdivisions 1, 4, by adding a subdivision; 256B.761; 256D.03,
2.17 subdivision 4; 256D.051, subdivision 2a; 256D.0515; 256D.06, subdivision
2.18 2; 256D.09, subdivision 6; 256D.44, subdivision 5; 256D.49, subdivision 3;
2.19 256G.02, subdivision 6; 256I.03, subdivision 7; 256I.05, subdivisions 1a, 7c;
2.20 256J.20, subdivision 3; 256J.24, subdivisions 5a, 10; 256J.37, subdivision
2.21 3a, by adding a subdivision; 256J.38, subdivision 1; 256J.45, subdivision 3;
2.22 256J.575, subdivisions 3, 6, 7; 256J.621; 256J.626, subdivision 6; 256J.751,
2.23 by adding a subdivision; 256J.95, subdivision 12; 256L.04, subdivision 10a,
2.24 by adding a subdivision; 256L.05, subdivision 1, by adding subdivisions;
2.25 256L.11, subdivisions 1, 7; 256L.12, subdivision 9; 256L.17, subdivision 3;
2.26 259.67, by adding a subdivision; 259.89, subdivision 1; 260C.317, subdivision
2.27 4; 270A.09, by adding a subdivision; 327.14, by adding a subdivision; 327.15;
2.28 327.16; 327.20, subdivision 1, by adding a subdivision; 393.07, subdivision
2.29 10; 501B.89, by adding a subdivision; 518A.53, subdivisions 1, 4, 10; 519.05;
2.30 604A.33, subdivision 1; 609.232, subdivision 11; 626.556, subdivision 3c;
2.31 626.5572, subdivisions 6, 13, 21; Laws 2003, First Special Session chapter 14,
2.32 article 13C, section 2, subdivision 1, as amended; Laws 2007, chapter 147,
2.33 article 19, section 3, subdivision 4, as amended; proposing coding for new
2.34 law in Minnesota Statutes, chapters 62Q; 144; 156; 246B; 254B; 256; 256B;
2.35 proposing coding for new law as Minnesota Statutes, chapter 402A; repealing
2.36 Minnesota Statutes 2008, sections 62U.08; 103I.112; 144.9501, subdivision
2.37 17b; 148D.180, subdivision 8; 246.51, subdivision 1; 246.53, subdivision 3;
2.38 256.962, subdivision 7; 256B.0655, subdivisions 1, 1a, 1c, 1d, 1e, 1f, 1g, 1h, 1i,
2.39 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13; 256B.071, subdivisions 1, 2, 3, 4; 256B.092,
2.40 subdivision 5a; 256B.19, subdivision 1d; 256B.431, subdivision 23; 256D.46;
2.41 256I.06, subdivision 9; 256J.626, subdivision 7; 259.83, subdivision 3; 259.89,
2.42 subdivisions 2, 3, 4; 327.14, subdivisions 5, 6; Laws 1988, chapter 689, section
2.43 251; Minnesota Rules, parts 4626.2015, subpart 9; 9100.0400, subparts 1, 3;
2.44 9100.0500; 9100.0600; 9500.1243, subpart 3; 9500.1261, subparts 3, 4, 5, 6;
2.45 9555.6125, subpart 4, item B.

2.46 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

2.47 **ARTICLE 1**

2.48 **LICENSING**

2.49 Section 1. Minnesota Statutes 2008, section 245A.10, subdivision 2, is amended to
2.50 read:

Subd. 2. **County fees for background studies and licensing inspections.** (a) For purposes of family and group family child care licensing under this chapter, a county agency may charge a fee to an applicant or license holder to recover the actual cost of background studies, but in any case not to exceed $100 annually. A county agency may also charge a license fee to an applicant or license holder not to exceed $50 for a one-year license or $100 for a two-year license.

(b) A county agency may charge a fee to a legal nonlicensed child care provider or applicant for authorization to recover the actual cost of background studies completed under section 119B.125, but in any case not to exceed $100 annually.

(c) Counties may elect to reduce or waive the fees in paragraph (a) or (b):

(1) in cases of financial hardship;

(2) if the county has a shortage of providers in the county's area;

(3) for new providers; or

(4) for providers who have attained at least 16 hours of training before seeking initial licensure.

(d) Counties may allow providers to pay the applicant fees in paragraph (a) or (b) on an installment basis for up to one year. If the provider is receiving child care assistance payments from the state, the provider may have the fees under paragraph (a) or (b) deducted from the child care assistance payments for up to one year and the state shall reimburse the county for the county fees collected in this manner.

(e) For purposes of adult foster care and child foster care licensing under this chapter, a county agency may charge a fee to a corporate applicant or corporate license holder to recover ~~the actual cost of background studies. A county agency may also charge a fee to a corporate applicant or corporate license holder to recover~~ the actual cost of licensing inspections, not to exceed $500 annually.

(f) Counties may elect to reduce or waive the fees in paragraph (e) under the following circumstances:

(1) in cases of financial hardship;

(2) if the county has a shortage of providers in the county's area; or

(3) for new providers.

Sec. 2. Minnesota Statutes 2008, section 245A.10, subdivision 3, is amended to read:

Subd. 3. **Application fee for initial license or certification.** (a) For fees required under subdivision 1, an applicant for an initial license or certification issued by the commissioner shall submit a ~~$500~~ $750 application fee with each new application required under this subdivision. The application fee shall not be prorated, is nonrefundable, and

is in lieu of the annual license or certification fee that expires on December 31. The commissioner shall not process an application until the application fee is paid.

(b) Except as provided in clauses (1) to (3), an applicant shall apply for a license to provide services at a specific location.

(1) For a license to provide ~~waivered~~ residential-based habilitation services to persons with developmental disabilities ~~or related conditions~~ under chapter 245B, an applicant shall submit an application for each county in which the ~~waivered~~ services will be provided. Upon licensure, the license holder may provide services to persons in that county plus no more than three persons at any one time in each of up to ten additional counties. A license holder in one county may not provide services under the home and community-based waiver for persons with developmental disabilities to more than three people in a second county without holding a separate license for that second county. Applicants or licensees providing services under this clause to not more than three persons remain subject to the inspection fees established in section 245A.10, subdivision 2, for each location.

(2) For a license to provide supported employment, crisis respite, or semi-independent living services to persons with developmental disabilities ~~or related conditions~~ under chapter 245B, an applicant shall submit a single application to provide services statewide.

(3) For a license to provide independent living assistance for youth under section 245A.22, an applicant shall submit a single application to provide services statewide.

Sec. 3. Minnesota Statutes 2008, section 245A.10, subdivision 4, is amended to read:

Subd. 4. **License ~~or certification~~ fee for ~~certain programs~~ a child care center.** ~~(a)~~ A child care ~~centers and programs with a licensed capacity~~ center shall pay an annual nonrefundable license ~~or certification~~ fee based on the following schedule:

Licensed Capacity	Child Care Center License Fee Fiscal Year 2010	~~Other Program~~ License Fee Fiscal Year 2011 and thereafter
1 to 24 persons	~~$225~~ $295	~~$400~~ $360
25 to 49 persons	~~$340~~ $410	~~$600~~ $475
50 to 74 persons	~~$450~~ $520	~~$800~~ $585
75 to 99 persons	~~$565~~ $635	~~$1,000~~ $700
100 to 124 persons	~~$675~~ $745	~~$1,200~~ $810
125 to 149 persons	~~$900~~ $970	~~$1,400~~ $1,035
150 to 174 persons	~~$1,050~~ $1,120	~~$1,600~~ $1,185

175 to 199 persons	~~$1,200~~ $1,270	~~$1,800~~ $1,335
200 to 224 persons	~~$1,350~~ $1,420	~~$2,000~~ $1,485
225 or more persons	~~$1,500~~ $1,570	~~$2,500~~ $1,635

~~(b) A day training and habilitation program serving persons with developmental disabilities or related conditions shall be assessed a license fee based on the schedule in paragraph (a) unless the license holder serves more than 50 percent of the same persons at two or more locations in the community. Except as provided in paragraph (c), when a day training and habilitation program serves more than 50 percent of the same persons in two or more locations in a community, the day training and habilitation program shall pay a license fee based on the licensed capacity of the largest facility and the other facility or facilities shall be charged a license fee based on a licensed capacity of a residential program serving one to 24 persons.~~

~~(c) When a day training and habilitation program serving persons with developmental disabilities or related conditions seeks a single license allowed under section 245B.07, subdivision 12, clause (2) or (3), the licensing fee must be based on the combined licensed capacity for each location.~~

Sec. 4. Minnesota Statutes 2008, section 245A.10, is amended by adding a subdivision to read:

Subd. 4a. **License fee for an adult day care center.** An adult day care center licensed under Minnesota Rules, parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee Fiscal Year 2010	License Fee Fiscal Year 2011 and thereafter
1 to 24 persons	$930	$1,460
25 to 49 persons	$1,130	$1,660
50 to 74 persons	$1,330	$1,860
75 to 99 persons	$1,530	$2,060
100 or more persons	$1,730	$2,260

Sec. 5. Minnesota Statutes 2008, section 245A.10, is amended by adding a subdivision to read:

Subd. 4b. **License fee for day training and habilitation program.** (a) A day training and habilitation program licensed under chapter 245B to provide services to

6.1 persons with developmental disabilities shall pay an annual nonrefundable license fee
6.2 based on the following schedule:

Licensed Capacity	License Fee Fiscal Year 2010	License Fee Fiscal Year 2011 and thereafter
1 to 24 persons	$925	$1,430
25 to 49 persons	$1,125	$1,630
50 to 74 persons	$1,325	$1,830
75 to 99 persons	$1,525	$2,030
100 to 124 persons	$1,725	$2,230
125 to 149 persons	$1,925	$2,430
150 to 174 persons	$2,125	$2,630
175 to 199 persons	$2,325	$2,830
200 to 224 persons	$2,525	$3,030
225 or more persons	$3,025	$3,530

6.15 (b) A day training and habilitation program licensed under chapter 245B must
6.16 be assessed a license fee based on the schedule in paragraph (a) unless the license
6.17 holder serves more than 50 percent of the same persons at two or more locations in the
6.18 community. Except as provided in paragraph (c), when a day training and habilitation
6.19 program serves more than 50 percent of the same persons in two or more locations in a
6.20 community, the day training and habilitation program shall pay a license fee based on the
6.21 licensed capacity of the largest facility and the other facility or facilities must be charged a
6.22 license fee based on a licensed capacity of a residential program serving one to 24 persons.
6.23 (c) When a day training and habilitation program serving persons with developmental
6.24 disabilities seeks a single license allowed under section 245B.07, subdivision 12, clause (2)
6.25 or (3), the licensing fee must be based on the combined licensed capacity for each location.

6.26 Sec. 6. Minnesota Statutes 2008, section 245A.10, is amended by adding a subdivision
6.27 to read:
6.28 Subd. 4c. **License fee for residential program serving persons with**
6.29 **developmental disabilities.** A residential program licensed under chapter 245B whether
6.30 certified as an intermediate care facility for persons with developmental disabilities or not
6.31 shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee Fiscal Year 2010	License Fee Fiscal Year 2011 and thereafter
1 to 24 persons	$1,000	$1,600
25 to 49 persons	$1,200	$1,800
50 to 74 persons	$1,400	$2,000
75 or more persons	$1,600	$2,200

7.1 Sec. 7. Minnesota Statutes 2008, section 245A.10, is amended by adding a subdivision
7.2 to read:
7.3 Subd. 4d. **License fee for program providing crisis respite.** (a) In fiscal year
7.4 2010, a program licensed to provide crisis respite services for persons with developmental
7.5 disabilities under chapter 245B shall pay an annual nonrefundable license fee of $1,600.
7.6 (b) In fiscal year 2011 and thereafter, a program licensed to provide crisis respite
7.7 services for persons with developmental disabilities under chapter 245B shall pay an
7.8 annual nonrefundable license fee of $2,000.

7.9 Sec. 8. Minnesota Statutes 2008, section 245A.10, is amended by adding a subdivision
7.10 to read:
7.11 Subd. 4e. **License fee for program providing residential-based habilitation**
7.12 **services.** (a) In fiscal year 2010, a program licensed to provide residential-based
7.13 habilitation services for persons with developmental disabilities under chapter 245B
7.14 shall pay an annual nonrefundable license fee that is based on a base rate of $715 plus
7.15 $50 times the number of clients served on the first day of August of the current license
7.16 year. State-operated programs are exempt from the license fee under this paragraph and
7.17 paragraph (b).
7.18 (b) In fiscal year 2011 and thereafter, a program licensed to provide residential-based
7.19 habilitation services for persons with developmental disabilities under chapter 245B shall
7.20 pay an annual nonrefundable license fee that is based on a base rate of $1,000 plus $70
7.21 times the number of clients served on the first day of August of the current license year.

7.22 Sec. 9. Minnesota Statutes 2008, section 245A.10, is amended by adding a subdivision
7.23 to read:
7.24 Subd. 4f. **License fee for program providing semi-independent living services**
7.25 **or supported employment services.** (a) In fiscal year 2010, a program licensed to
7.26 provide semi-independent living services for persons with developmental disabilities
7.27 under chapter 245B or supported employment services for persons with developmental
7.28 disabilities under chapter 245B shall pay an annual nonrefundable license fee of $1,250.
7.29 (b) In fiscal year 2011 and thereafter, a program licensed to provide semi-independent
7.30 living services for persons with developmental disabilities under chapter 245B or
7.31 supported employment services for persons with developmental disabilities under chapter
7.32 245B shall pay an annual nonrefundable license fee of $2,000.

8.1 Sec. 10. Minnesota Statutes 2008, section 245A.10, is amended by adding a
8.2 subdivision to read:

8.3 Subd. 4g. **License fee for residential program serving persons with physical**
8.4 **disabilities.** A residential program licensed under Minnesota Rules, parts 9570.2000 to
8.5 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable
8.6 license fee based on the following schedule:

	Licensed Capacity	License Fee Fiscal Year 2010	License Fee Fiscal Year 2011 and thereafter
8.7–8.8			
8.9	1 to 24 persons	$713	$1,025
8.10	25 to 49 persons	$913	$1,225
8.11	50 to 74 persons	$1,113	$1,425
8.12	75 to 99 persons	$1,313	$1,625
8.13	100 to 124 persons	$1,513	$1,825
8.14	125 or more persons	$1,713	$2,025

8.15 Sec. 11. Minnesota Statutes 2008, section 245A.10, is amended by adding a
8.16 subdivision to read:

8.17 Subd. 4h. **License fee for residential programs serving adults with mental**
8.18 **illness.** (a) In fiscal year 2010, a residential program licensed under Minnesota Rules,
8.19 parts 9520.0500 to 9520.0670, to serve adults with mental illness shall pay an annual
8.20 nonrefundable license fee of $2,450.

8.21 (b) In fiscal year 2011 and thereafter, a residential program licensed under Minnesota
8.22 Rules, parts 9520.0500 to 9520.0670, to serve adults with mental illness shall pay an
8.23 annual nonrefundable license fee of $4,400.

8.24 Sec. 12. Minnesota Statutes 2008, section 245A.10, is amended by adding a
8.25 subdivision to read:

8.26 Subd. 4i. **License fee for a children's residential program.** (a) In fiscal year 2010,
8.27 a children's residential program licensed under Minnesota Rules, chapter 2960, shall pay
8.28 an annual nonrefundable license fee of $2,450.

8.29 (b) In fiscal year 2011 and thereafter, a children's residential program licensed under
8.30 Minnesota Rules, chapter 2960, shall pay an annual nonrefundable license fee of $4,400.

8.31 Sec. 13. Minnesota Statutes 2008, section 245A.10, is amended by adding a
8.32 subdivision to read:

8.33 Subd. 4j. **License fee for programs licensed to provide drug or chemical**
8.34 **dependency treatment.** (a) A program licensed under Minnesota Rules, parts 9530.6405

9.1 to 9.2: to 9530.6505 or 9530.6510 to 9530.6590, to provide drug or chemical dependency treatment shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee Fiscal Year 2010	License Fee Fiscal Year 2011 and thereafter
1 to 24 persons	$755	$1,035
25 to 49 persons	$955	$1,235
50 to 74 persons	$1,155	$1,435
75 to 99 persons	$1,355	$1,635
100 to 124 persons	$1,555	$1,835
125 or more persons	$1,755	$2,035

(b) In fiscal year 2010, if a license issued to a program under Minnesota Rules, parts 9530.6405 to 9530.6505, does not have a stated licensed capacity, the drug or chemical dependency treatment program shall pay an annual nonrefundable license fee based on a licensed capacity of one to 24 persons for fiscal year 2010.

(c) In fiscal year 2011 and thereafter, if a license issued to a program under Minnesota Rules, parts 9530.6405 to 9530.6505, does not have a stated licensed capacity, the drug or chemical dependency treatment program shall pay an annual nonrefundable license fee based on a licensed capacity of one to 24 persons for fiscal year 2011 and thereafter.

Sec. 14. Minnesota Statutes 2008, section 245A.10, is amended by adding a subdivision to read:

Subd. 4k. **License fee for independent living assistance for youth.** A program licensed to provide independent living assistance for youth under section 245A.22, shall pay an annual nonrefundable license fee of $2,000.

Sec. 15. Minnesota Statutes 2008, section 245A.10, is amended by adding a subdivision to read:

Subd. 4l. **License fee for private agencies that provide child foster care or adoption services.** A private agency licensed under Minnesota Rules, parts 9545.0755 to 9545.0845, to provide child foster care or adoption services shall pay an annual nonrefundable license fee of $400.

Sec. 16. Minnesota Statutes 2008, section 245A.10, subdivision 5, is amended to read:

Subd. 5. ~~**License or**~~ **Mental health center or mental health clinic certification fee** ~~**for other programs.**~~ ~~(a) Except as provided in paragraphs (b) and (c), a program without a stated licensed capacity shall pay a license or certification fee of $400.~~

10.1 <s>(b)</s> A mental health center or mental health clinic requesting certification for
10.2 purposes of insurance and subscriber contract reimbursement under Minnesota Rules,
10.3 parts 9520.0750 to 9520.0870, shall pay a certification fee of $1,000 per year. If the
10.4 mental health center or mental health clinic provides services at a primary location with
10.5 satellite facilities, the satellite facilities shall be certified with the primary location without
10.6 an additional charge.

10.7 <s>(c) A program licensed to provide residential-based habilitation services under the</s>
10.8 <s>home and community-based waiver for persons with developmental disabilities shall pay</s>
10.9 <s>an annual license fee that includes a base rate of $250 plus $38 times the number of clients</s>
10.10 <s>served on the first day of August of the current license year. State-operated programs are</s>
10.11 <s>exempt from the license fee under this paragraph.</s>

10.12 Sec. 17. Minnesota Statutes 2008, section 245A.10, is amended by adding a
10.13 subdivision to read:

10.14 <u>Subd. 7.</u> <u>**Human services licensing revenue and appropriations.**</u> <u>Effective July</u>
10.15 <u>1, 2011:</u>

10.16 <u>(1) departmental earnings collected under subdivisions 3, 4 to 4l, and 5 shall be</u>
10.17 <u>deposited in the state government special revenue fund; and</u>

10.18 <u>(2) the direct appropriation to the department for licensing activities in subdivisions</u>
10.19 <u>3, 4 to 4l, and 5 shall be transferred from the general fund to the state government special</u>
10.20 <u>revenue fund.</u>

10.21 Sec. 18. Minnesota Statutes 2008, section 245A.11, subdivision 2a, is amended to read:

10.22 Subd. 2a. **Adult foster care license capacity.** <u>The commissioner shall issue adult</u>
10.23 <u>foster care licenses with a maximum licensed capacity of four beds, including nonstaff</u>
10.24 <u>roomers and boarders, except that the commissioner may issue a license with a capacity of</u>
10.25 <u>five beds, including roomers and boarders, according to paragraphs (a) to (e).</u>

10.26 (a) An adult foster care license holder may have a maximum license capacity of five
10.27 if all persons in care are age 55 or over and do not have a serious and persistent mental
10.28 illness or a developmental disability.

10.29 (b) The commissioner may grant variances to paragraph (a) to allow a foster care
10.30 provider with a licensed capacity of five persons to admit an individual under the age of 55
10.31 if the variance complies with section 245A.04, subdivision 9, and approval of the variance
10.32 is recommended by the county in which the licensed foster care provider is located.

10.33 (c) The commissioner may grant variances to paragraph (a) to allow the use of a fifth
10.34 bed for emergency crisis services for a person with serious and persistent mental illness

11.1 or a developmental disability, regardless of age, if the variance complies with section
11.2 245A.04, subdivision 9, and approval of the variance is recommended by the county in
11.3 which the licensed foster care provider is located.

11.4 (d) ~~Notwithstanding paragraph (a),~~ If the 2009 legislature adopts a rate reduction
11.5 that impacts providers of adult foster care services, the commissioner may issue an adult
11.6 foster care license with a capacity of five adults if the fifth bed does not increase the
11.7 overall statewide capacity of licensed adult foster care beds in homes that are not the
11.8 primary residence of the license holder, over the licensed capacity in such homes on July
11.9 1, 2009, as identified in a plan submitted to the commissioner by the county, when the
11.10 capacity is recommended by the county licensing agency of the county in which the
11.11 facility is located and if the recommendation verifies that:

11.12 (1) the facility meets the physical environment requirements in the adult foster
11.13 care licensing rule;

11.14 (2) the five-bed living arrangement is specified for each resident in the resident's:

11.15 (i) individualized plan of care;

11.16 (ii) individual service plan under section 256B.092, subdivision 1b, if required; or

11.17 (iii) individual resident placement agreement under Minnesota Rules, part
11.18 9555.5105, subpart 19, if required;

11.19 (3) the license holder obtains written and signed informed consent from each
11.20 resident or resident's legal representative documenting the resident's informed choice to
11.21 living in the home and that the resident's refusal to consent would not have resulted in
11.22 service termination; and

11.23 (4) the facility was licensed for adult foster care before March 1, ~~2003~~ 2009.

11.24 (e) The commissioner shall not issue a new adult foster care license under paragraph
11.25 (d) after June 30, ~~2005~~ 2011. The commissioner shall allow a facility with an adult foster
11.26 care license issued under paragraph (d) before June 30, ~~2005~~ 2011, to continue with a
11.27 capacity of five adults if the license holder continues to comply with the requirements in
11.28 paragraph (d).

11.29 **EFFECTIVE DATE.** This section is effective July 1, 2009.

11.30 Sec. 19. Minnesota Statutes 2008, section 245A.11, is amended by adding a
11.31 subdivision to read:

11.32 Subd. 8. **Alternate overnight supervision technology; adult foster care license.**
11.33 (a) The commissioner may grant an applicant or license holder an adult foster care license
11.34 for a residence that does not have a caregiver in the residence during normal sleeping
11.35 hours as required under Minnesota Rules, part 9555.5105, subpart 37, item B, but uses

12.1 monitoring technology to alert the license holder when an incident occurs that may
12.2 jeopardize the health, safety, or rights of a foster care recipient. The applicant or license
12.3 holder must comply with all other requirements under Minnesota Rules, parts 9555.5105
12.4 to 9555.6265, and the requirements under this subdivision. The license printed by the
12.5 commissioner must state in bold and large font:

12.6 (1) that staff are not present on-site overnight; and

12.7 (2) the telephone number of the county's common entry point for making reports of
12.8 suspected maltreatment of vulnerable adults under section 626.557, subdivision 9.

12.9 (b) Applications for a license under this section must be submitted directly to
12.10 the Department of Human Services licensing division. The licensing division must
12.11 immediately notify the host county and lead county contract agency and the host county
12.12 licensing agency. The licensing division must collaborate with the county licensing
12.13 agency in the review of the application and the licensing of the program.

12.14 (c) Before a license is issued by the commissioner, and for the duration of the license,
12.15 the applicant or license holder must establish, maintain, and document the implementation
12.16 of written policies and procedures addressing the requirements in paragraphs (d) to (f).

12.17 (d) The applicant or license holder must have policies and procedures that:

12.18 (1) establish characteristics of target populations that will be admitted into the home
12.19 and characteristics of populations that will not be accepted into the home;

12.20 (2) explain the discharge process when a foster care recipient requires overnight
12.21 supervision or other services that cannot be provided by the license holder due to the
12.22 limited hours that the license holder is on-site;

12.23 (3) describe the types of events to which the program will respond with a physical
12.24 presence when those events occur in the home during time when staff are not on-site, and
12.25 how the license holder's response plan meets the requirements in paragraph (e), clause
12.26 (1) or (2);

12.27 (4) establish a process for documenting a review of the implementation and
12.28 effectiveness of the response protocol for the response required under paragraph (e),
12.29 clause (1) or (2). The documentation must include:

12.30 (i) a description of the triggering incident;

12.31 (ii) the date and time of the triggering incident;

12.32 (iii) the time of the response or responses under paragraph (e), clause (1) or (2);

12.33 (iv) whether the response met the resident's needs;

12.34 (v) whether the existing policies and response protocols were followed; and

12.35 (vi) whether the existing policies and protocols are adequate or need modification.

13.1 When no physical presence response is completed for a three-month period, the
13.2 license holder's written policies and procedures must require a physical presence response
13.3 drill be to conducted for which the effectiveness of the response protocol under paragraph
13.4 (e), clause (1) or (2), will be reviewed and documented as required under this clause; and
13.5 (5) establish that emergency and nonemergency phone numbers are posted in a
13.6 prominent location in a common area of the home where they can be easily observed by a
13.7 person responding to an incident who is not otherwise affiliated with the home.
13.8 (e) The license holder must document and include in the license application which
13.9 response alternative under clause (1) or (2) is in place for responding to situations that
13.10 present a serious risk to the health, safety, or rights of people receiving foster care services
13.11 in the home:
13.12 (1) response alternative (1) requires only the technology to provide an electronic
13.13 notification or alert to the license holder that an event is underway that requires a response.
13.14 Under this alternative, no more than ten minutes will pass before the license holder will be
13.15 physically present on-site to respond to the situation; or
13.16 (2) response alternative (2) requires the electronic notification and alert system
13.17 under alternative (1), but more than ten minutes may pass before the license holder is
13.18 present on-site to respond to the situation. Under alternative (2), all of the following
13.19 conditions are met:
13.20 (i) the license holder has a written description of the interactive technological
13.21 applications that will assist the licenser holder in communicating with and assessing the
13.22 needs related to care, health, and safety of the foster care recipients. This interactive
13.23 technology must permit the license holder to remotely assess the well being of the foster
13.24 care recipient without requiring the initiation or participation by the foster care recipient.
13.25 Requiring the foster care recipient to initiate a telephone call or answer a telephone call
13.26 does not meet this requirement;
13.27 (ii) the license holder documents how the remote license holder is qualified and
13.28 capable of meeting the needs of the foster care recipients and assessing foster care
13.29 recipients' needs under item (i), during the absence of the license holder on-site;
13.30 (iii) the license holder maintains written procedures to dispatch emergency response
13.31 personnel to the site in the event of an identified emergency; and
13.32 (iv) each foster care recipient's individualized plan of care, individual service plan
13.33 under section 256B.092, subdivision 1b, if required, or individual resident placement
13.34 agreement under Minnesota Rules, part 9555.5105, subpart 19, if required, identifies the
13.35 maximum response time, which may be greater than ten minutes, for the license holder
13.36 to be on-site for that foster care recipient.

14.1 (f) All placement agreements, individual service agreements, and plans applicable
14.2 to the foster care recipient must clearly state that the adult foster care license category is
14.3 a program without the presence of a caregiver in the residence during normal sleeping
14.4 hours; the protocols in place for responding to situations that present a serious risk to
14.5 health, safety, or rights of foster care recipients under paragraph (e), clause (1) or (2); and a
14.6 signed informed consent from each foster care recipient or the person's legal representative
14.7 documenting the person's or legal representative's agreement with placement in the
14.8 program. If electronic monitoring technology is used in the home, the informed consent
14.9 form must also explain the following:

14.10 (1) how any electronic monitoring is incorporated into the alternative supervision
14.11 system;

14.12 (2) the backup system for any electronic monitoring in times of electrical outages or
14.13 other equipment malfunctions;

14.14 (3) how the license holder is trained on the use of the technology;

14.15 (4) the event types and license holder response times established under paragraph (e);

14.16 (5) how the license holder protects the foster care recipient's privacy related to
14.17 electronic monitoring and related to any electronically recorded data generated by the
14.18 monitoring system. The consent form must explain where and how the electronically
14.19 recorded data is stored, with whom it will be shared, and how long it is retained; and

14.20 (6) the risks and benefits of the alternative overnight supervision system.

14.21 The written explanations under clauses (1) to (6) may be accomplished through
14.22 cross-references to other policies and procedures as long as they are explained to the
14.23 person giving consent, and the person giving consent is offered a copy.

14.24 (g) Nothing in this section requires the applicant or license holder to develop or
14.25 maintain separate or duplicative policies, procedures, documentation, consent forms, or
14.26 individual plans that may be required for other licensing standards, if the requirements of
14.27 this section are incorporated into those documents.

14.28 (h) The commissioner may grant variances to the requirements of this section
14.29 according to section 245A.04, subdivision 9.

14.30 (i) For the purposes of paragraphs (c) to (h), "license holder" has the meaning
14.31 under section 245A.02, subdivision 9, and additionally includes all staff, volunteers, and
14.32 contractors affiliated with the license holder.

14.33 Sec. 20. Minnesota Statutes 2008, section 245A.16, subdivision 1, is amended to read:

14.34 Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and
14.35 private agencies that have been designated or licensed by the commissioner to perform

15.1 licensing functions and activities under section 245A.04 and background studies for
15.2 ~~adult foster care,~~ family adult day services~~,~~ and family child care~~,~~ under chapter 245C; to
15.3 recommend denial of applicants under section 245A.05; to issue correction orders, to issue
15.4 variances, and recommend a conditional license under section 245A.06, or to recommend
15.5 suspending or revoking a license or issuing a fine under section 245A.07, shall comply
15.6 with rules and directives of the commissioner governing those functions and with this
15.7 section. The following variances are excluded from the delegation of variance authority
15.8 and may be issued only by the commissioner:

15.9 (1) dual licensure of family child care and child foster care, dual licensure of child
15.10 and adult foster care, and adult foster care and family child care;

15.11 (2) adult foster care maximum capacity;

15.12 (3) adult foster care minimum age requirement;

15.13 (4) child foster care maximum age requirement;

15.14 (5) variances regarding disqualified individuals except that county agencies may
15.15 issue variances under section 245C.30 regarding disqualified individuals when the county
15.16 is responsible for conducting a consolidated reconsideration according to sections 245C.25
15.17 and 245C.27, subdivision 2, clauses (a) and (b), of a county maltreatment determination
15.18 and a disqualification based on serious or recurring maltreatment; and

15.19 (6) the required presence of a caregiver in the adult foster care residence during
15.20 normal sleeping hours.

15.21 (b) County agencies must report information about disqualification reconsiderations
15.22 under sections 245C.25 and 245C.27, subdivision 2, paragraphs (a) and (b), and variances
15.23 granted under paragraph (a), clause (5), to the commissioner at least monthly in a format
15.24 prescribed by the commissioner.

15.25 (c) For family day care programs, the commissioner may authorize licensing reviews
15.26 every two years after a licensee has had at least one annual review.

15.27 (d) For family adult day services programs, the commissioner may authorize
15.28 licensing reviews every two years after a licensee has had at least one annual review.

15.29 (e) A license issued under this section may be issued for up to two years.

15.30 Sec. 21. Minnesota Statutes 2008, section 245A.16, subdivision 3, is amended to read:

15.31 Subd. 3. **Recommendations to commissioner.** The county or private agency
15.32 shall not make recommendations to the commissioner regarding licensure without first
15.33 conducting an inspection, and for ~~adult foster care,~~ family adult day services~~,~~ and family
15.34 child care, a background study of the applicant under chapter 245C. The county or private

16.1 agency must forward its recommendation to the commissioner regarding the appropriate
16.2 licensing action within 20 working days of receipt of a completed application.

16.3 Sec. 22. Minnesota Statutes 2008, section 245C.04, subdivision 1, is amended to read:
16.4 Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a
16.5 background study of an individual required to be studied under section 245C.03,
16.6 subdivision 1, at least upon application for initial license for all license types.
16.7 (b) The commissioner shall conduct a background study of an individual required to
16.8 be studied under section 245C.03, subdivision 1, at reapplication for a license for ~~adult~~
16.9 ~~foster care,~~ family adult day services~~,~~ and family child care.
16.10 (c) The commissioner is not required to conduct a study of an individual at the time
16.11 of reapplication for a license if the individual's background study was completed by the
16.12 commissioner of human services for an adult foster care license holder that is also:
16.13 (1) registered under chapter 144D; or
16.14 (2) licensed to provide home and community-based services to people with
16.15 disabilities at the foster care location and the license holder does not reside in the foster
16.16 care residence; and
16.17 (3) the following conditions are met:
16.18 (i) a study of the individual was conducted either at the time of initial licensure or
16.19 when the individual became affiliated with the license holder;
16.20 (ii) the individual has been continuously affiliated with the license holder since
16.21 the last study was conducted; and
16.22 (iii) the last study of the individual was conducted on or after October 1, 1995.
16.23 (d) From July 1, 2007, to June 30, 2009, the commissioner of human services shall
16.24 conduct a study of an individual required to be studied under section 245C.03, at the
16.25 time of reapplication for a child foster care license. The county or private agency shall
16.26 collect and forward to the commissioner the information required under section 245C.05,
16.27 subdivisions 1, paragraphs (a) and (b), and 5, paragraphs (a) and (b). The background
16.28 study conducted by the commissioner of human services under this paragraph must
16.29 include a review of the information required under section 245C.08, subdivisions 1,
16.30 paragraph (a), clauses (1) to (5), 3, and 4.
16.31 (e) The commissioner of human services shall conduct a background study of an
16.32 individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2)
16.33 to (6), who is newly affiliated with a child foster care license holder. The county or
16.34 private agency shall collect and forward to the commissioner the information required
16.35 under section 245C.05, subdivisions 1 and 5. The background study conducted by the

17.1 commissioner of human services under this paragraph must include a review of the
17.2 information required under section 245C.08, subdivisions 1, 3, and 4.
17.3 (f) From January 1, 2010, to December 31, 2012, unless otherwise specified in
17.4 paragraph (c), the commissioner shall conduct a study of an individual required to be
17.5 studied under section 245C.03 at the time of reapplication for an adult foster care license.
17.6 The county shall collect and forward to the commissioner the information required under
17.7 section 245C.05, subdivision 1, paragraphs (a) and (b), and subdivision 5, paragraphs (a)
17.8 and (b). The background study conducted by the commissioner under this paragraph
17.9 must include a review of the information required under section 245C.08, subdivision 1,
17.10 paragraph (a), clauses (1) to (5), and subdivisions 3 and 4.
17.11 (g) The commissioner shall conduct a background study of an individual specified
17.12 under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly
17.13 affiliated with an adult foster care license holder. The county shall collect and forward
17.14 to the commissioner the information required under section 245C.05, subdivision 1,
17.15 paragraphs (a) and (b), and subdivision 5, paragraphs (a) and (b). The background
17.16 study conducted by the commissioner under this paragraph must include a review of
17.17 the information required under section 245C.08, subdivision 1, paragraph (a), and
17.18 subdivisions 3 and 4.
17.19 (h) Applicants for licensure, license holders, and other entities as provided in this
17.20 chapter must submit completed background study forms to the commissioner before
17.21 individuals specified in section 245C.03, subdivision 1, begin positions allowing direct
17.22 contact in any licensed program.
17.23 ~~(g)~~ (i) For purposes of this section, a physician licensed under chapter 147 is
17.24 considered to be continuously affiliated upon the license holder's receipt from the
17.25 commissioner of health or human services of the physician's background study results.

17.26 Sec. 23. Minnesota Statutes 2008, section 245C.05, subdivision 4, is amended to read:
17.27 Subd. 4. **Electronic transmission.** For background studies conducted by the
17.28 Department of Human Services, the commissioner shall implement a system for the
17.29 electronic transmission of:
17.30 (1) background study information to the commissioner;
17.31 (2) background study results to the license holder; ~~and~~
17.32 (3) background study results to county and private agencies for background studies
17.33 conducted by the commissioner for child foster care; and
17.34 (4) background study results to county agencies for background studies conducted
17.35 by the commissioner for adult foster care.

Sec. 24. Minnesota Statutes 2008, section 245C.08, subdivision 2, is amended to read:

Subd. 2. **Background studies conducted by a county agency.** (a) For a background study conducted by a county agency for ~~adult foster care,~~ family adult day services~~,~~ and family child care services, the commissioner shall review:

(1) information from the county agency's record of substantiated maltreatment of adults and the maltreatment of minors;

(2) information from juvenile courts as required in subdivision 4 for individuals listed in section 245C.03, subdivision 1, clauses (2), (5), and (6); and

(3) information from the Bureau of Criminal Apprehension.

(b) If the individual has resided in the county for less than five years, the study shall include the records specified under paragraph (a) for the previous county or counties of residence for the past five years.

(c) Notwithstanding expungement by a court, the county agency may consider information obtained under paragraph (a), clause (3), unless the commissioner received notice of the petition for expungement and the court order for expungement is directed specifically to the commissioner.

Sec. 25. Minnesota Statutes 2008, section 245C.10, is amended by adding a subdivision to read:

Subd. 5. **Adult foster care services.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 1, for the purposes of adult foster care licensing, through a fee of no more than $20 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 26. Minnesota Statutes 2008, section 245C.10, is amended by adding a subdivision to read:

Subd. 8. **Private agencies.** The commissioner shall recover the cost of conducting background studies under section 245C.33 for studies initiated by private agencies for the purpose of adoption through a fee of no more than $70 per study charged to the private agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 27. Minnesota Statutes 2008, section 245C.17, is amended by adding a subdivision to read:

19.1 Subd. 6. **Notice to county agency.** For studies on individuals related to a license to
19.2 provide adult foster care, the commissioner shall also provide a notice of the background
19.3 study results to the county agency that initiated the background study.

19.4 Sec. 28. Minnesota Statutes 2008, section 245C.20, is amended to read:

19.5 **245C.20 LICENSE HOLDER RECORD KEEPING.**

19.6 A licensed program shall document the date the program initiates a background
19.7 study under this chapter in the program's personnel files. When a background study is
19.8 completed under this chapter, a licensed program shall maintain a notice that the study
19.9 was undertaken and completed in the program's personnel files. Except when background
19.10 studies are initiated through the commissioner's online system, if a licensed program
19.11 has not received a response from the commissioner under section 245C.17 within 45
19.12 days of initiation of the background study request, the licensed program must contact the
19.13 ~~commissioner~~ human services licensing division to inquire about the status of the study. If
19.14 a license holder initiates a background study under the commissioner's online system, but
19.15 the background study subject's name does not appear in the list of active or recent studies
19.16 initiated by that license holder, the license holder must either contact the human services
19.17 licensing division or resubmit the background study information online for that individual.

19.18 Sec. 29. Minnesota Statutes 2008, section 245C.21, subdivision 1a, is amended to read:

19.19 Subd. 1a. **Submission of reconsideration request ~~to county or private agency~~.**
19.20 (a) For disqualifications related to studies conducted by county agencies for family child
19.21 care and family adult day services, and for disqualifications related to studies conducted
19.22 by the commissioner for child foster care and adult foster care, the individual shall
19.23 submit the request for reconsideration to the county ~~or private~~ agency that initiated the
19.24 background study.

19.25 (b) For disqualifications related to studies conducted by the commissioner for child
19.26 foster care, the individual shall submit the request for reconsideration to the private agency
19.27 that initiated the background study.

19.28 (c) A reconsideration request shall be submitted within 30 days of the individual's
19.29 receipt of the disqualification notice or the time frames specified in subdivision 2,
19.30 whichever time frame is shorter.

19.31 ~~(c)~~ (d) The county or private agency shall forward the individual's request for
19.32 reconsideration and provide the commissioner with a recommendation whether to set aside
19.33 the individual's disqualification.

20.1 Sec. 30. Minnesota Statutes 2008, section 245C.23, subdivision 2, is amended to read:

20.2 Subd. 2. **Commissioner's notice of disqualification that is not set aside.** (a) The
20.3 commissioner shall notify the license holder of the disqualification and order the license
20.4 holder to immediately remove the individual from any position allowing direct contact
20.5 with persons receiving services from the license holder if:

20.6 (1) the individual studied does not submit a timely request for reconsideration
20.7 under section 245C.21;

20.8 (2) the individual submits a timely request for reconsideration, but the commissioner
20.9 does not set aside the disqualification for that license holder under section 245C.22;

20.10 (3) an individual who has a right to request a hearing under sections 245C.27 and
20.11 256.045, or 245C.28 and chapter 14 for a disqualification that has not been set aside, does
20.12 not request a hearing within the specified time; or

20.13 (4) an individual submitted a timely request for a hearing under sections 245C.27
20.14 and 256.045, or 245C.28 and chapter 14, but the commissioner does not set aside the
20.15 disqualification under section 245A.08, subdivision 5, or 256.045.

20.16 (b) If the commissioner does not set aside the disqualification under section 245C.22,
20.17 and the license holder was previously ordered under section 245C.17 to immediately
20.18 remove the disqualified individual from direct contact with persons receiving services or
20.19 to ensure that the individual is under continuous, direct supervision when providing direct
20.20 contact services, the order remains in effect pending the outcome of a hearing under
20.21 sections 245C.27 and 256.045, or 245C.28 and chapter 14.

20.22 (c) For background studies related to child foster care, the commissioner shall
20.23 also notify the county or private agency that initiated the study of the results of the
20.24 reconsideration.

20.25 (d) For background studies related to adult foster care, the commissioner shall also
20.26 notify the county that initiated the study of the results of the reconsideration.

20.27 Sec. 31. Minnesota Statutes 2008, section 256B.092, is amended by adding a
20.28 subdivision to read:

20.29 Subd. 5b. **Revised per diem based on legislated rate reduction.** Notwithstanding
20.30 section 252.28, subdivision 3, paragraph (d), if the 2009 legislature adopts a rate reduction
20.31 that impacts payment to providers of adult foster care services, the commissioner may
20.32 issue adult foster care licenses that permit a capacity of five adults. The application for a
20.33 five-bed license must meet the requirements of section 245A.11, subdivision 2a. Prior to
20.34 admission of the fifth recipient of adult foster care services, the county must negotiate a
20.35 revised per diem rate for room and board and waiver services that reflects the legislated

21.1 rate reduction and results in an overall average per diem reduction for all foster care
21.2 recipients in that home. The revised per diem must allow the provider to maintain, as
21.3 much as possible, the level of services or enhanced services provided in the residence,
21.4 while mitigating the losses of the legislated rate reduction.

21.5 **EFFECTIVE DATE.** This section is effective July 1, 2009.

21.6 Sec. 32. Minnesota Statutes 2008, section 256B.0945, subdivision 4, is amended to
21.7 read:

21.8 Subd. 4. **Payment rates.** (a) Notwithstanding sections 256B.19 and 256B.041,
21.9 payments to counties for residential services provided by a residential facility shall only
21.10 be made of federal earnings for services provided under this section, and the nonfederal
21.11 share of costs for services provided under this section shall be paid by the county from
21.12 sources other than federal funds or funds used to match other federal funds. Payment to
21.13 counties for services provided according to this section shall be a proportion of the per
21.14 day contract rate that relates to rehabilitative mental health services and shall not include
21.15 payment for costs or services that are billed to the IV-E program as room and board.

21.16 (b) Per diem rates paid to providers under this section by prepaid plans shall be the
21.17 proportion of the per-day contract rate that relates to rehabilitative mental health services
21.18 and shall not include payment for group foster care costs or services that are billed to the
21.19 county of financial responsibility.

21.20 (c) The commissioner shall ~~set aside a portion not to exceed~~ retain five percent of the
21.21 federal funds earned for county expenditures under this section to cover the state costs
21.22 of administering this section, and to reduce licensing fees charged to facilities providing
21.23 services under this section. ~~Any unexpended funds from the set-aside shall be distributed~~
21.24 ~~to the counties in proportion to their earnings under this section.~~

21.25 Sec. 33. Minnesota Statutes 2008, section 256B.49, subdivision 17, is amended to read:

21.26 Subd. 17. **Cost of services and supports.** (a) The commissioner shall ensure
21.27 that the average per capita expenditures estimated in any fiscal year for home and
21.28 community-based waiver recipients does not exceed the average per capita expenditures
21.29 that would have been made to provide institutional services for recipients in the absence
21.30 of the waiver.

21.31 (b) The commissioner shall implement on January 1, 2002, one or more aggregate,
21.32 need-based methods for allocating to local agencies the home and community-based
21.33 waivered service resources available to support recipients with disabilities in need of
21.34 the level of care provided in a nursing facility or a hospital. The commissioner shall

22.1 allocate resources to single counties and county partnerships in a manner that reflects
22.2 consideration of:
22.3 (1) an incentive-based payment process for achieving outcomes;
22.4 (2) the need for a state-level risk pool;
22.5 (3) the need for retention of management responsibility at the state agency level; and
22.6 (4) a phase-in strategy as appropriate.
22.7 (c) Until the allocation methods described in paragraph (b) are implemented, the
22.8 annual allowable reimbursement level of home and community-based waiver services
22.9 shall be the greater of:
22.10 (1) the statewide average payment amount which the recipient is assigned under the
22.11 waiver reimbursement system in place on June 30, 2001, modified by the percentage of
22.12 any provider rate increase appropriated for home and community-based services; or
22.13 (2) an amount approved by the commissioner based on the recipient's extraordinary
22.14 needs that cannot be met within the current allowable reimbursement level. The
22.15 increased reimbursement level must be necessary to allow the recipient to be discharged
22.16 from an institution or to prevent imminent placement in an institution. The additional
22.17 reimbursement may be used to secure environmental modifications; assistive technology
22.18 and equipment; and increased costs for supervision, training, and support services
22.19 necessary to address the recipient's extraordinary needs. The commissioner may approve
22.20 an increased reimbursement level for up to one year of the recipient's relocation from an
22.21 institution or up to six months of a determination that a current waiver recipient is at
22.22 imminent risk of being placed in an institution.
22.23 (d) Beginning July 1, 2001, medically necessary private duty nursing services will be
22.24 authorized under this section as complex and regular care according to sections 256B.0651
22.25 and 256B.0653 to 256B.0656. The rate established by the commissioner for registered
22.26 nurse or licensed practical nurse services under any home and community-based waiver as
22.27 of January 1, 2001, shall not be reduced.
22.28 (e) Notwithstanding section 252.28, subdivision 3, paragraph (d), if the 2009
22.29 legislature adopts a rate reduction that impacts payment to providers of adult foster care
22.30 services, the commissioner may issue adult foster care licenses that permit a capacity of
22.31 five adults. The application for a five-bed license must meet the requirements of section
22.32 245A.11, subdivision 2a. Prior to admission of the fifth recipient of adult foster care
22.33 services, the county must negotiate a revised per diem rate for room and board and waiver
22.34 services that reflects the legislated rate reduction and results in an overall average per
22.35 diem reduction for all foster care recipients in that home. The revised per diem must allow

23.1 the provider to maintain, as much as possible, the level of services or enhanced services
23.2 provided in the residence, while mitigating the losses of the legislated rate reduction.

23.3 **EFFECTIVE DATE.** This section is effective July 1, 2009.

23.4 Sec. 34. **WAIVER.**

23.5 By December 1, 2009, the commissioner shall request all federal approvals and
23.6 waiver amendments to the disability home and community-based waivers to allow properly
23.7 licensed adult foster care homes to provide residential services for up to five individuals.

23.8 **EFFECTIVE DATE.** This section is effective July 1, 2009.

23.9 Sec. 35. **REPEALER.**

23.10 (a) Minnesota Statutes 2008, section 256B.092, subdivision 5a, is repealed effective
23.11 July 1, 2009.

23.12 (b) Minnesota Rules, part 9555.6125, subpart 4, item B, is repealed.

23.13 **ARTICLE 2**

23.14 **MFIP, CHILDREN, AND ADULT SUPPORTS**

23.15 Section 1. Minnesota Statutes 2008, section 256D.051, subdivision 2a, is amended to
23.16 read:

23.17 Subd. 2a. **Duties of commissioner.** In addition to any other duties imposed by law,
23.18 the commissioner shall:

23.19 (1) based on this section and section 256D.052 and Code of Federal Regulations,
23.20 title 7, section 273.7, supervise the administration of food stamp employment and training
23.21 services to county agencies;

23.22 (2) disburse money appropriated for food stamp employment and training services
23.23 to county agencies based upon the county's costs as specified in section 256D.051,
23.24 subdivision 6c;

23.25 (3) accept and supervise the disbursement of any funds that may be provided by the
23.26 federal government or from other sources for use in this state for food stamp employment
23.27 and training services;

23.28 (4) apply for the maximum allowable federal matching funds under United States
23.29 Code, title 7, section 2025, paragraph (h), for state expenditures made on behalf of family
23.30 stabilization services participants voluntarily engaged in food stamp employment and
23.31 training activities, where appropriate;

(5) cooperate with other agencies including any agency of the United States or of another state in all matters concerning the powers and duties of the commissioner under this section and section 256D.052; and

~~(5)~~ (6) in cooperation with the commissioner of employment and economic development, ensure that each component of an employment and training program carried out under this section is delivered through a statewide workforce development system, unless the component is not available locally through such a system.

Sec. 2. Minnesota Statutes 2008, section 256D.0515, is amended to read:

256D.0515 ASSET LIMITATIONS FOR FOOD STAMP HOUSEHOLDS.

All food stamp households must be determined eligible for the benefit discussed under section 256.029. Food stamp households must demonstrate that~~:~~

~~(1)~~ their gross income meets the federal Food Stamp requirements under United States Code, title 7, section 2014(c)~~; and~~

~~(2) they have financial resources, excluding vehicles, of less than $7,000~~.

Sec. 3. Minnesota Statutes 2008, section 256D.06, subdivision 2, is amended to read:

Subd. 2. **Emergency need.** (a) Notwithstanding the provisions of subdivision 1, a grant of emergency general assistance shall, to the extent funds are available, be made to an eligible single adult, married couple, or family for an emergency need, ~~as defined in rules promulgated by the commissioner,~~ where the recipient requests temporary assistance not exceeding 30 days if an emergency situation appears to exist under criteria adopted by the county agency and the individual or family is ineligible for MFIP or DWP or is not a participant of MFIP or DWP and whose annual net income is no greater than 200 percent of the federal poverty level for the previous calendar year. If an applicant or recipient relates facts to the county agency which may be sufficient to constitute an emergency situation, the county agency shall, to the extent funds are available, advise the person of the procedure for applying for assistance according to this subdivision. An emergency general assistance grant is available to a recipient not more than once in any 12-month period.

(b) Funding for an emergency general assistance program is limited to the appropriation. Each fiscal year, the commissioner shall allocate to counties the money appropriated for emergency general assistance grants based on each county agency's average share of state's emergency general expenditures for the immediate past three fiscal years as determined by the commissioner, and may reallocate any unspent amounts to other counties.

(c) No county shall be allocated less than $1,000 for the fiscal year.

25.1 (d) Should an emergency be declared as provided in section 12.31, the commissioner
25.2 may immediately reallocate unspent funds without regard to the other provisions of this
25.3 section to meet the emergency needs. The emergency reallocation must be excluded from
25.4 calculations for subsequent allocations as provided in paragraphs (b) and (c).
25.5 (e) Any emergency general assistance expenditures by a county above the amount of
25.6 the commissioner's allocation to the county must be made from county funds.

25.7 Sec. 4. Minnesota Statutes 2008, section 256D.09, subdivision 6, is amended to read:
25.8 Subd. 6. **Recovery of overpayments.** (a) If an amount of general assistance or
25.9 family general assistance is paid to a recipient in excess of the payment due, it shall be
25.10 recoverable by the county agency. The agency shall give written notice to the recipient of
25.11 its intention to recover the overpayment.
25.12 (b) Except as provided for interim assistance in section 256D.06, subdivision
25.13 5, when an overpayment occurs, the county agency shall recover the overpayment
25.14 from a current recipient by reducing the amount of aid payable to the assistance unit of
25.15 which the recipient is a member, for one or more monthly assistance payments, until
25.16 the overpayment is repaid. All county agencies in the state shall reduce the assistance
25.17 payment by three percent of the assistance unit's standard of need in nonfraud cases and
25.18 ten percent where fraud has occurred, or the amount of the monthly payment, whichever is
25.19 less, for all overpayments.
25.20 (c) In cases when there is both an overpayment and underpayment, the county
25.21 agency shall offset one against the other in correcting the payment.
25.22 (d) Overpayments may also be voluntarily repaid, in part or in full, by the individual,
25.23 in addition to the aid reductions provided in this subdivision, to include further voluntary
25.24 reductions in the grant level agreed to in writing by the individual, until the total amount
25.25 of the overpayment is repaid.
25.26 (e) The county agency shall make reasonable efforts to recover overpayments to
25.27 persons no longer on assistance under standards adopted in rule by the commissioner
25.28 of human services. The county agency need not attempt to recover overpayments of
25.29 less than $35 paid to an individual no longer on assistance if the individual does not
25.30 receive assistance again within three years, unless the individual has been convicted of
25.31 violating section 256.98.
25.32 (f) Establishment of an overpayment is limited to 12 months prior to the month of
25.33 discovery due to an agency error and six years prior to the month of discovery due to a
25.34 client error or an intentional program violation determined under section 256.046.

26.1 Sec. 5. Minnesota Statutes 2008, section 256D.49, subdivision 3, is amended to read:
26.2 Subd. 3. **Overpayment of monthly grants and recovery of ATM errors.** (a) When
26.3 the county agency determines that an overpayment of the recipient's monthly payment
26.4 of Minnesota supplemental aid has occurred, it shall issue a notice of overpayment
26.5 to the recipient. If the person is no longer receiving Minnesota supplemental aid, the
26.6 county agency may request voluntary repayment or pursue civil recovery. If the person is
26.7 receiving Minnesota supplemental aid, the county agency shall recover the overpayment
26.8 by withholding an amount equal to three percent of the standard of assistance for the
26.9 recipient or the total amount of the monthly grant, whichever is less.
26.10 (b) Establishment of an overpayment is limited to 12 months prior to the month of
26.11 discovery due to an agency error and six years prior to the month of discovery due to a
26.12 client error or an intentional program violation determined under section 256.046.
26.13 (c) For recipients receiving benefits via electronic benefit transfer, if the overpayment
26.14 is a result of an automated teller machine (ATM) dispensing funds in error to the recipient,
26.15 the agency may recover the ATM error by immediately withdrawing funds from the
26.16 recipient's electronic benefit transfer account, up to the amount of the error.
26.17 (d) Residents of ~~nursing homes, regional treatment centers, and~~ licensed residential
26.18 facilities ~~with negotiated rates~~ shall not have overpayments recovered from their personal
26.19 needs allowance.

26.20 Sec. 6. Minnesota Statutes 2008, section 256I.03, subdivision 7, is amended to read:
26.21 Subd. 7. **Countable income.** "Countable income" means all income received by an
26.22 applicant or recipient less any applicable exclusions or disregards. For a recipient of any
26.23 cash benefit from the SSI program, countable income means the SSI benefit limit in effect
26.24 at the time the person is in a GRH ~~setting less $20~~, less the medical assistance personal
26.25 needs allowance. If the SSI limit has been reduced for a person due to events occurring
26.26 prior to the persons entering the GRH setting, countable income means actual income less
26.27 any applicable exclusions and disregards.

26.28 **EFFECTIVE DATE.** This section is effective April 1, 2010.

26.29 Sec. 7. Minnesota Statutes 2008, section 256I.05, subdivision 7c, is amended to read:
26.30 Subd. 7c. **Demonstration project.** The commissioner is authorized to pursue the
26.31 expansion of a demonstration project under federal food stamp regulation for the purpose
26.32 of gaining additional federal reimbursement of food and nutritional costs currently paid by
26.33 the state group residential housing program. The commissioner shall seek approval no

later than ~~January 1, 2004~~ October 1, 2009. Any reimbursement received is nondedicated revenue to the general fund.

Sec. 8. Minnesota Statutes 2008, section 256J.20, subdivision 3, is amended to read:

Subd. 3. **Other property limitations.** To be eligible for MFIP, the equity value of all nonexcluded real and personal property of the assistance unit must not exceed $2,000 for applicants and $5,000 for ongoing participants. The value of assets in clauses (1) to (19) must be excluded when determining the equity value of real and personal property:

(1) a licensed vehicle up to a loan value of less than or equal to ~~$15,000~~ $7,500. ~~If the assistance unit owns more than one licensed vehicle, the county agency shall determine the loan value of all additional vehicles and exclude the combined loan value of less than or equal to $7,500.~~ The county agency shall apply any excess loan value as if it were equity value to the asset limit described in this section~~,~~. If the assistance unit owns more than one licensed vehicle, the county agency shall determine the vehicle with the highest loan value and count only the loan value over $7,500, excluding: (i) the value of one vehicle per physically disabled person when the vehicle is needed to transport the disabled unit member; this exclusion does not apply to mentally disabled people; (ii) the value of special equipment for a disabled member of the assistance unit; and (iii) any vehicle used for long-distance travel, other than daily commuting, for the employment of a unit member.

The county agency shall count the loan value of all other vehicles and apply this amount as if it were equity value to the asset limit described in this section. To establish the loan value of vehicles, a county agency must use the N.A.D.A. Official Used Car Guide, Midwest Edition, for newer model cars. When a vehicle is not listed in the guidebook, or when the applicant or participant disputes the loan value listed in the guidebook as unreasonable given the condition of the particular vehicle, the county agency may require the applicant or participant document the loan value by securing a written statement from a motor vehicle dealer licensed under section 168.27, stating the amount that the dealer would pay to purchase the vehicle. The county agency shall reimburse the applicant or participant for the cost of a written statement that documents a lower loan value;

(2) the value of life insurance policies for members of the assistance unit;

(3) one burial plot per member of an assistance unit;

(4) the value of personal property needed to produce earned income, including tools, implements, farm animals, inventory, business loans, business checking and savings accounts used at least annually and used exclusively for the operation of a self-employment business, and any motor vehicles if at least 50 percent of the vehicle's use is to produce income and if the vehicles are essential for the self-employment business;

28.1 (5) the value of personal property not otherwise specified which is commonly
28.2 used by household members in day-to-day living such as clothing, necessary household
28.3 furniture, equipment, and other basic maintenance items essential for daily living;
28.4 (6) the value of real and personal property owned by a recipient of Supplemental
28.5 Security Income or Minnesota supplemental aid;
28.6 (7) the value of corrective payments, but only for the month in which the payment
28.7 is received and for the following month;
28.8 (8) a mobile home or other vehicle used by an applicant or participant as the
28.9 applicant's or participant's home;
28.10 (9) money in a separate escrow account that is needed to pay real estate taxes or
28.11 insurance and that is used for this purpose;
28.12 (10) money held in escrow to cover employee FICA, employee tax withholding,
28.13 sales tax withholding, employee worker compensation, business insurance, property rental,
28.14 property taxes, and other costs that are paid at least annually, but less often than monthly;
28.15 (11) monthly assistance payments for the current month's or short-term emergency
28.16 needs under section 256J.626, subdivision 2;
28.17 (12) the value of school loans, grants, or scholarships for the period they are
28.18 intended to cover;
28.19 (13) payments listed in section 256J.21, subdivision 2, clause (9), which are held
28.20 in escrow for a period not to exceed three months to replace or repair personal or real
28.21 property;
28.22 (14) income received in a budget month through the end of the payment month;
28.23 (15) savings from earned income of a minor child or a minor parent that are set aside
28.24 in a separate account designated specifically for future education or employment costs;
28.25 (16) the federal earned income credit, Minnesota working family credit, state and
28.26 federal income tax refunds, state homeowners and renters credits under chapter 290A,
28.27 property tax rebates and other federal or state tax rebates in the month received and the
28.28 following month;
28.29 (17) payments excluded under federal law as long as those payments are held in a
28.30 separate account from any nonexcluded funds;
28.31 (18) the assets of children ineligible to receive MFIP benefits because foster care or
28.32 adoption assistance payments are made on their behalf; and
28.33 (19) the assets of persons whose income is excluded under section 256J.21,
28.34 subdivision 2, clause (43).

28.35 **EFFECTIVE DATE.** This section is effective March 1, 2010.

29.1 Sec. 9. Minnesota Statutes 2008, section 256J.24, subdivision 5a, is amended to read:
29.2 Subd. 5a. **Food portion of MFIP transitional standard.** The commissioner
29.3 shall adjust the food portion of the MFIP transitional standard ~~by October 1 each year~~
29.4 ~~beginning October 1998~~ as needed to reflect ~~the cost-of-living~~ adjustments to the food
29.5 ~~Stamp~~ support program. The commissioner shall ~~annually~~ publish ~~in the State Register~~
29.6 the transitional standard for an assistance unit of sizes one to ten in the State Register
29.7 whenever an adjustment is made.

29.8 **EFFECTIVE DATE.** This section is effective October 1, 2009.

29.9 Sec. 10. Minnesota Statutes 2008, section 256J.24, subdivision 10, is amended to read:
29.10 Subd. 10. **MFIP exit level.** The commissioner shall adjust the MFIP earned income
29.11 disregard to ensure that most participants do not lose eligibility for MFIP until their
29.12 income reaches at least ~~115~~ 110 percent of the federal poverty guidelines in effect ~~in~~
29.13 ~~October of each fiscal year~~ at the time of the adjustment. The adjustment to the disregard
29.14 shall be based on a household size of three, and the resulting earned income disregard
29.15 percentage must be applied to all household sizes. The adjustment under this subdivision
29.16 must be implemented ~~at the same time as the October food stamp or~~ whenever there is a
29.17 food support ~~cost-of-living~~ adjustment ~~is~~ reflected in the food portion of MFIP transitional
29.18 standard as required under subdivision 5a.

29.19 **EFFECTIVE DATE.** This section is effective October 1, 2010.

29.20 Sec. 11. Minnesota Statutes 2008, section 256J.37, subdivision 3a, is amended to read:
29.21 Subd. 3a. **Rental subsidies; unearned income.** (a) ~~Effective July 1, 2003,~~ The
29.22 county agency shall count ~~$50~~ $100 of the value of public and assisted rental subsidies
29.23 provided through the Department of Housing and Urban Development (HUD) as unearned
29.24 income to the cash portion of the MFIP grant. The full amount of the subsidy must be
29.25 counted as unearned income when the subsidy is less than ~~$50~~ $100. The income from
29.26 this subsidy shall be budgeted according to section 256J.34.
29.27 (b) The provisions of this subdivision shall not apply to an MFIP assistance unit
29.28 which includes a participant who is:
29.29 (1) age 60 or older;
29.30 (2) a caregiver who is suffering from an illness, injury, or incapacity that has been
29.31 certified by a qualified professional when the illness, injury, or incapacity is expected
29.32 to continue for more than 30 days and prevents the person from obtaining or retaining
29.33 employment; or

30.1 (3) a caregiver whose presence in the home is required due to the illness or
30.2 incapacity of another member in the assistance unit, a relative in the household, or a foster
30.3 child in the household when the illness or incapacity and the need for the participant's
30.4 presence in the home has been certified by a qualified professional and is expected to
30.5 continue for more than 30 days.

30.6 (c) The provisions of this subdivision shall not apply to an MFIP assistance unit
30.7 where the parental caregiver is an SSI recipient.

30.8 (d) Prior to implementing this provision, the commissioner must identify the MFIP
30.9 participants subject to this provision and provide written notice to these participants at
30.10 least 30 days before the first grant reduction. The notice must inform the participant of the
30.11 basis for the potential grant reduction, the exceptions to the provision, if any, and inform
30.12 the participant of the steps necessary to claim an exception. A person who is found not to
30.13 meet one of the exceptions to the provision must be notified and informed of the right to a
30.14 fair hearing under section 256J.40. The notice must also inform the participant that the
30.15 participant may be eligible for a rent reduction resulting from a reduction in the MFIP
30.16 grant and encourage the participant to contact the local housing authority.

30.17 **EFFECTIVE DATE.** This section is effective October 1, 2010.

30.18 Sec. 12. Minnesota Statutes 2008, section 256J.37, is amended by adding a subdivision
30.19 to read:

30.20 Subd. 11. **Treatment of Supplemental Security Income.** Effective March 1,
30.21 2010, the county shall reduce the cash portion of the MFIP grant by up to $70 for an
30.22 MFIP assistance unit that includes one or more Supplemental Security Income (SSI)
30.23 recipients who reside in the household, and who would otherwise be included in the
30.24 MFIP assistance unit under section 256J.24, subdivision 2, but are excluded solely due to
30.25 the SSI recipient status under section 256J.24, subdivision 3, paragraph (a), clause (1).
30.26 If the SSI recipient or recipients receive less than $70 of SSI, only the amount received
30.27 must be used in calculating the MFIP cash assistance payment. This provision does not
30.28 apply to relative caregivers who could elect to be included in the MFIP assistance unit
30.29 under section 256J.24, subdivision 4, unless the caregiver's children or stepchildren are
30.30 included in the MFIP assistance unit.

30.31 **EFFECTIVE DATE.** This section is effective October 1, 2010.

30.32 Sec. 13. Minnesota Statutes 2008, section 256J.38, subdivision 1, is amended to read:

31.1 Subdivision 1. **Scope of overpayment.** (a) When a participant or former participant
31.2 receives an overpayment due to agency, client, or ATM error, or due to assistance received
31.3 while an appeal is pending and the participant or former participant is determined
31.4 ineligible for assistance or for less assistance than was received, the county agency must
31.5 recoup or recover the overpayment using the following methods:

31.6 (1) reconstruct each affected budget month and corresponding payment month;

31.7 (2) use the policies and procedures that were in effect for the payment month; and

31.8 (3) do not allow employment disregards in section 256J.21, subdivision 3 or 4, in the
31.9 calculation of the overpayment when the unit has not reported within two calendar months
31.10 following the end of the month in which the income was received.

31.11 (b) Establishment of an overpayment is limited to 12 months prior to the month of
31.12 discovery due to agency error and six years prior to the month of discovery due to client
31.13 error or an intentional program violation determined under section 256.046.

31.14 Sec. 14. Minnesota Statutes 2008, section 256J.575, subdivision 3, is amended to read:

31.15 Subd. 3. **Eligibility.** (a) The following MFIP ~~or diversionary work program (DWP)~~
31.16 participants are eligible for the services under this section:

31.17 (1) a participant who meets the requirements for or has been granted a hardship
31.18 extension under section 256J.425, subdivision 2 or 3, except that it is not necessary for
31.19 the participant to have reached or be approaching 60 months of eligibility for this section
31.20 to apply;

31.21 (2) a participant who is applying for Supplemental Security Income or Social
31.22 Security disability insurance; and

31.23 (3) a participant who is a noncitizen who has been in the United States for 12 or
31.24 fewer months.

31.25 (b) Families must meet all other eligibility requirements for MFIP established in
31.26 this chapter. Families are eligible for financial assistance to the same extent as if they
31.27 were participating in MFIP.

31.28 (c) A participant under paragraph (a), clause (3), must be provided with English as a
31.29 second language opportunities and skills training for up to 12 months. After 12 months,
31.30 the case manager and participant must determine whether the participant should continue
31.31 with English as a second language classes or skills training, or both, and continue to
31.32 receive family stabilization services.

31.33 **EFFECTIVE DATE.** This section is effective March 1, 2010.

31.34 Sec. 15. Minnesota Statutes 2008, section 256J.575, subdivision 6, is amended to read:

32.1 Subd. 6. **Cooperation with services requirements.** (a) ~~To be eligible,~~ A participant
32.2 who is eligible for family stabilization services under this section shall comply with
32.3 paragraphs (b) to (d).
32.4 (b) Participants shall engage in family stabilization plan services for the appropriate
32.5 number of hours per week that the activities are scheduled and available, unless good
32.6 cause exists for not doing so, as defined in section 256J.57, subdivision 1. The appropriate
32.7 number of hours must be based on the participant's plan.
32.8 (c) The case manager shall review the participant's progress toward the goals in the
32.9 family stabilization plan every six months to determine whether conditions have changed,
32.10 including whether revisions to the plan are needed.
32.11 (d) A participant's requirement to comply with any or all family stabilization plan
32.12 requirements under this subdivision is excused when the case management services,
32.13 training and educational services, or family support services identified in the participant's
32.14 family stabilization plan are unavailable for reasons beyond the control of the participant,
32.15 including when money appropriated is not sufficient to provide the services.

32.16 Sec. 16. Minnesota Statutes 2008, section 256J.575, subdivision 7, is amended to read:
32.17 Subd. 7. **Sanctions.** (a) The county agency or employment services provider must
32.18 follow the requirements of this subdivision at the time the county agency or employment
32.19 services provider has information that an MFIP recipient may meet the eligibility criteria
32.20 in subdivision 3.
32.21 (b) The financial assistance grant of a participating family is reduced according to
32.22 section 256J.46, if a participating adult fails without good cause to comply or continue
32.23 to comply with the family stabilization plan requirements in this subdivision, unless
32.24 compliance has been excused under subdivision 6, paragraph (d).
32.25 ~~(b)~~ (c) Given the purpose of the family stabilization services in this section and the
32.26 nature of the underlying family circumstances that act as barriers to both employment and
32.27 full compliance with program requirements, there must be a review by the county agency
32.28 prior to imposing a sanction to determine whether the plan was appropriated to the needs
32.29 of the participant and family~~, and~~. There must be a current assessment by a behavioral
32.30 health or medical professional confirming that the participant in all ways had the ability to
32.31 comply with the plan~~, as confirmed by a behavioral health or medical professional~~.
32.32 ~~(c)~~ (d) Prior to the imposition of a sanction, the county agency or employment
32.33 services provider shall review the participant's case to determine if the family stabilization
32.34 plan is still appropriate and meet with the participant face-to-face. ~~The participant may~~

33.1 ~~bring an advocate~~ The county agency or employment services provider must inform the
33.2 participant of the right to bring an advocate to the face-to-face meeting.

33.3 During the face-to-face meeting, the county agency shall:

33.4 (1) determine whether the continued noncompliance can be explained and mitigated
33.5 by providing a needed family stabilization service, as defined in subdivision 2, paragraph
33.6 (d);

33.7 (2) determine whether the participant qualifies for a good cause exception under
33.8 section 256J.57, or if the sanction is for noncooperation with child support requirements,
33.9 determine if the participant qualifies for a good cause exemption under section 256.741,
33.10 subdivision 10;

33.11 (3) determine whether activities in the family stabilization plan are appropriate
33.12 based on the family's circumstances;

33.13 (4) explain the consequences of continuing noncompliance;

33.14 (5) identify other resources that may be available to the participant to meet the
33.15 needs of the family; and

33.16 (6) inform the participant of the right to appeal under section 256J.40.

33.17 If the lack of an identified activity or service can explain the noncompliance, the
33.18 county shall work with the participant to provide the identified activity.

33.19 (d) If the participant fails to come to the face-to-face meeting, the case manager or a
33.20 designee shall attempt at least one home visit. If a face-to-face meeting is not conducted,
33.21 the county agency shall send the participant a written notice that includes the information
33.22 under paragraph (c).

33.23 (e) After the requirements of paragraphs (c) and (d) are met and prior to imposition
33.24 of a sanction, the county agency shall provide a notice of intent to sanction under section
33.25 256J.57, subdivision 2, and, when applicable, a notice of adverse action under section
33.26 256J.31.

33.27 (f) Section 256J.57 applies to this section except to the extent that it is modified
33.28 by this subdivision.

33.29 Sec. 17. Minnesota Statutes 2008, section 256J.621, is amended to read:

33.30 **256J.621 WORK PARTICIPATION CASH BENEFITS.**

33.31 (a) Effective October 1, 2009, upon exiting the diversionary work program (DWP)
33.32 or upon terminating the Minnesota family investment program with earnings, a participant
33.33 who is employed may be eligible for work participation cash benefits of ~~$75~~ $50 per
33.34 month to assist in meeting the family's basic needs as the participant continues to move
33.35 toward self-sufficiency.

34.1 (b) To be eligible for work participation cash benefits, the participant shall not
34.2 receive MFIP or diversionary work program assistance during the month and the
34.3 participant or participants must meet the following work requirements:
34.4 (1) if the participant is a single caregiver and has a child under six years of age, the
34.5 participant must be employed at least 87 hours per month;
34.6 (2) if the participant is a single caregiver and does not have a child under six years of
34.7 age, the participant must be employed at least 130 hours per month; or
34.8 (3) if the household is a two-parent family, at least one of the parents must be
34.9 employed an average of at least 130 hours per month.
34.10 Whenever a participant exits the diversionary work program or is terminated from
34.11 MFIP and meets the other criteria in this section, work participation cash benefits are
34.12 available for up to 24 consecutive months.
34.13 (c) Expenditures on the program are maintenance of effort state funds under
34.14 a separate state program for participants under paragraph (b), clauses (1) and (2).
34.15 Expenditures for participants under paragraph (b), clause (3), are nonmaintenance of effort
34.16 funds. Months in which a participant receives work participation cash benefits under this
34.17 section do not count toward the participant's MFIP 60-month time limit.

34.18 Sec. 18. Minnesota Statutes 2008, section 256J.626, subdivision 6, is amended to read:
34.19 Subd. 6. **Base allocation to counties and tribes; definitions.** (a) For purposes of
34.20 this section, the following terms have the meanings given.
34.21 (1) "2002 historic spending base" means the commissioner's determination of
34.22 the sum of the reimbursement related to fiscal year 2002 of county or tribal agency
34.23 expenditures for the base programs listed in clause ~~(6)~~ (5), items (i) through (iv), and
34.24 earnings related to calendar year 2002 in the base program listed in clause ~~(6)~~ (5), item
34.25 (v), and the amount of spending in fiscal year 2002 in the base program listed in clause
34.26 ~~(6)~~ (5), item (vi), issued to or on behalf of persons residing in the county or tribal service
34.27 delivery area.
34.28 (2) "Adjusted caseload factor" means a factor weighted:
34.29 (i) 47 percent on the MFIP cases in each county at four points in time in the most
34.30 recent 12-month period for which data is available multiplied by the county's caseload
34.31 difficulty factor; and
34.32 (ii) 53 percent on the count of adults on MFIP in each county and tribe at four points
34.33 in time in the most recent 12-month period for which data is available multiplied by the
34.34 county or tribe's caseload difficulty factor.

35.1 (3) "Caseload difficulty factor" means a factor determined by the commissioner for
35.2 each county and tribe based upon the self-support index described in section 256J.751,
35.3 subdivision 2, clause (6).

35.4 ~~(4) "Initial allocation" means the amount potentially available to each county or tribe~~
35.5 ~~based on the formula in paragraphs (b) through (d).~~

35.6 ~~(5)~~ (4) "Final allocation" means the amount available to each county or tribe based
35.7 on the formula in paragraphs (b) ~~through (d), after adjustment by subdivision 7~~ and (c).

35.8 ~~(6)~~ (5) "Base programs" means the:

35.9 (i) MFIP employment and training services under Minnesota Statutes 2002, section
35.10 256J.62, subdivision 1, in effect June 30, 2002;

35.11 (ii) bilingual employment and training services to refugees under Minnesota Statutes
35.12 2002, section 256J.62, subdivision 6, in effect June 30, 2002;

35.13 (iii) work literacy language programs under Minnesota Statutes 2002, section
35.14 256J.62, subdivision 7, in effect June 30, 2002;

35.15 (iv) supported work program authorized in Laws 2001, First Special Session chapter
35.16 9, article 17, section 2, in effect June 30, 2002;

35.17 (v) administrative aid program under section 256J.76 in effect December 31, 2002;
35.18 and

35.19 (vi) emergency assistance program under Minnesota Statutes 2002, section 256J.48,
35.20 in effect June 30, 2002.

35.21 (b) The commissioner shall~~:~~

35.22 ~~(1) beginning July 1, 2003, determine the initial allocation of funds available under~~
35.23 ~~this section according to clause (2);~~

35.24 ~~(2) allocate all of the funds available for the period beginning July 1, 2003, and~~
35.25 ~~ending December 31, 2004, to each county or tribe in proportion to the county's or tribe's~~
35.26 ~~share of the statewide 2002 historic spending base;~~

35.27 ~~(3) determine for calendar year 2005 the initial allocation of funds to be made~~
35.28 ~~available under this section in proportion to the county or tribe's initial allocation for the~~
35.29 ~~period of July 1, 2003, to December 31, 2004;~~

35.30 ~~(4) determine for calendar year 2006 the initial allocation of funds to be made~~
35.31 ~~available under this section based 90 percent on the proportion of the county or tribe's~~
35.32 ~~share of the statewide 2002 historic spending base and ten percent on the proportion of~~
35.33 ~~the county or tribe's share of the adjusted caseload factor;~~

35.34 ~~(5) determine for calendar year 2007 the initial allocation of funds to be made~~
35.35 ~~available under this section based 70 percent on the proportion of the county or tribe's~~

36.1 ~~share of the statewide 2002 historic spending base and 30 percent on the proportion of the~~
36.2 ~~county or tribe's share of the adjusted caseload factor; and~~
36.3 ~~(6) determine for calendar year 2008 and subsequent years the initial allocation of~~
36.4 allocate funds to be made available under this section based 50 percent on the proportion
36.5 of the county or tribe's share of the statewide 2002 historic spending base and 50 percent
36.6 on the proportion of the county or tribe's share of the adjusted caseload factor.
36.7 (c) With the commencement of a new or expanded tribal TANF program or an
36.8 agreement under section 256.01, subdivision 2, paragraph (g), in which some or all of
36.9 the responsibilities of particular counties under this section are transferred to a tribe,
36.10 the commissioner shall:
36.11 (1) in the case where all responsibilities under this section are transferred to a tribal
36.12 program, determine the percentage of the county's current caseload that is transferring to a
36.13 tribal program and adjust the affected county's allocation accordingly; and
36.14 (2) in the case where a portion of the responsibilities under this section are
36.15 transferred to a tribal program, the commissioner shall consult with the affected county or
36.16 counties to determine an appropriate adjustment to the allocation.
36.17 ~~(d) Effective January 1, 2005, counties and tribes will have their final allocations~~
36.18 ~~adjusted based on the performance provisions of subdivision 7.~~

36.19 **EFFECTIVE DATE.** This section is effective July 1, 2010.

36.20 Sec. 19. Minnesota Statutes 2008, section 256J.751, is amended by adding a
36.21 subdivision to read:
36.22 Subd. 2a. **County performance standards.** (a) For the purpose of this section, the
36.23 following terms have the meanings given:
36.24 (1) "Caseload reduction credit" (CRC) means the measure of how much the
36.25 Minnesota TANF caseload, including the separate state program caseload, has fallen
36.26 relative to the federal fiscal year 2005 caseload based on caseload data from October
36.27 1 to September 30.
36.28 (2) "TANF participation rate target" means a 50 percent participation rate reduced by
36.29 the CRC as calculated by the Department of Human Services.
36.30 (b) A county or tribe shall negotiate a multiyear improvement plan with the
36.31 commissioner if the county or tribe does not:
36.32 (1) achieve the TANF participation rate target or a five percentage point improvement
36.33 over the county or tribe's previous year's TANF participation rate under subdivision 2,
36.34 clause (7), as averaged across 12 consecutive months for the most recent year for which
36.35 the measurements are available; or

(2) perform within or above its range of expected performance on the annualized three-year self-support index under subdivision 2, clause (6).

(c) A county or tribe that has successfully negotiated an improvement plan must provide a semiannual report indicating that the plan has been implemented, the impact of the plan, and any anticipated changes to the plan.

Sec. 20. Minnesota Statutes 2008, section 256J.95, subdivision 12, is amended to read:

Subd. 12. **Conversion or referral to MFIP.** (a) If at any time during the DWP application process or during the four-month DWP eligibility period, it is determined that a participant is unlikely to benefit from the diversionary work program, the county shall convert or refer the participant to MFIP as specified in paragraph (d). Participants who are determined to be unlikely to benefit from the diversionary work program must develop and sign an employment plan. ~~Participants who meet any one of the criteria in paragraph (b) shall be considered to be unlikely to benefit from DWP, provided the necessary documentation is available to support the determination.~~

(b) A participant who~~:~~ meets the eligibility requirements under section 256J.575, subdivision 3, must be considered to be unlikely to benefit from DWP, provided the necessary documentation is available to support the determination.

~~(1) has been determined by a qualified professional as being unable to obtain or retain employment due to an illness, injury, or incapacity that is expected to last at least 60 days;~~

~~(2) is required in the home as a caregiver because of the illness, injury, or incapacity, of a family member, or a relative in the household, or a foster child, and the illness, injury, or incapacity and the need for a person to provide assistance in the home has been certified by a qualified professional and is expected to continue more than 60 days;~~

~~(3) is determined by a qualified professional as being needed in the home to care for a child or adult meeting the special medical criteria in section 256J.561, subdivision 2, paragraph (d), clause (3);~~

~~(4) is pregnant and is determined by a qualified professional as being unable to obtain or retain employment due to the pregnancy; or~~

~~(5) has applied for SSI or SSDI.~~

(c) In a two-parent family unit, ~~both parents must be~~ if one parent is determined to be unlikely to benefit from the diversionary work program ~~before~~, the family unit ~~can~~ must be converted or referred to MFIP.

(d) A participant who is determined to be unlikely to benefit from the diversionary work program shall be converted to MFIP and, if the determination was made within 30 days of the initial application for benefits, no additional application form is required.

38.1 A participant who is determined to be unlikely to benefit from the diversionary work
38.2 program shall be referred to MFIP and, if the determination is made more than 30
38.3 days after the initial application, the participant must submit a program change request
38.4 form. The county agency shall process the program change request form by the first of
38.5 the following month to ensure that no gap in benefits is due to delayed action by the
38.6 county agency. In processing the program change request form, the county must follow
38.7 section 256J.32, subdivision 1, except that the county agency shall not require additional
38.8 verification of the information in the case file from the DWP application unless the
38.9 information in the case file is inaccurate, questionable, or no longer current.
38.10 (e) The county shall not request a combined application form for a participant who
38.11 has exhausted the four months of the diversionary work program, has continued need for
38.12 cash and food assistance, and has completed, signed, and submitted a program change
38.13 request form within 30 days of the fourth month of the diversionary work program. The
38.14 county must process the program change request according to section 256J.32, subdivision
38.15 1, except that the county agency shall not require additional verification of information
38.16 in the case file unless the information is inaccurate, questionable, or no longer current.
38.17 When a participant does not request MFIP within 30 days of the diversionary work
38.18 program benefits being exhausted, a new combined application form must be completed
38.19 for any subsequent request for MFIP.

38.20 **EFFECTIVE DATE.** This section is effective March 1, 2010.

38.21 Sec. 21. Minnesota Statutes 2008, section 393.07, subdivision 10, is amended to read:
38.22 Subd. 10. **Food stamp program; Maternal and Child Nutrition Act.** (a) The local
38.23 social services agency shall establish and administer the food stamp program according
38.24 to rules of the commissioner of human services, the supervision of the commissioner as
38.25 specified in section 256.01, and all federal laws and regulations. The commissioner of
38.26 human services shall monitor food stamp program delivery on an ongoing basis to ensure
38.27 that each county complies with federal laws and regulations. Program requirements to be
38.28 monitored include, but are not limited to, number of applications, number of approvals,
38.29 number of cases pending, length of time required to process each application and deliver
38.30 benefits, number of applicants eligible for expedited issuance, length of time required
38.31 to process and deliver expedited issuance, number of terminations and reasons for
38.32 terminations, client profiles by age, household composition and income level and sources,
38.33 and the use of phone certification and home visits. The commissioner shall determine the
38.34 county-by-county and statewide participation rate.

39.1 (b) On July 1 of each year, the commissioner of human services shall determine a
39.2 statewide and county-by-county food stamp program participation rate. The commissioner
39.3 may designate a different agency to administer the food stamp program in a county if the
39.4 agency administering the program fails to increase the food stamp program participation
39.5 rate among families or eligible individuals, or comply with all federal laws and regulations
39.6 governing the food stamp program. The commissioner shall review agency performance
39.7 annually to determine compliance with this paragraph.

39.8 (c) A person who commits any of the following acts has violated section 256.98 or
39.9 609.821, or both, and is subject to both the criminal and civil penalties provided under
39.10 those sections:

39.11 (1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a
39.12 willful statement or misrepresentation, or intentional concealment of a material fact, food
39.13 stamps or vouchers issued according to sections 145.891 to 145.897 to which the person
39.14 is not entitled or in an amount greater than that to which that person is entitled or which
39.15 specify nutritional supplements to which that person is not entitled; or

39.16 (2) presents or causes to be presented, coupons or vouchers issued according to
39.17 sections 145.891 to 145.897 for payment or redemption knowing them to have been
39.18 received, transferred or used in a manner contrary to existing state or federal law; or

39.19 (3) willfully uses, possesses, or transfers food stamp coupons, authorization to
39.20 purchase cards or vouchers issued according to sections 145.891 to 145.897 in any manner
39.21 contrary to existing state or federal law, rules, or regulations; or

39.22 (4) buys or sells food stamp coupons, authorization to purchase cards, other
39.23 assistance transaction devices, vouchers issued according to sections 145.891 to 145.897,
39.24 or any food obtained through the redemption of vouchers issued according to sections
39.25 145.891 to 145.897 for cash or consideration other than eligible food.

39.26 (d) A peace officer or welfare fraud investigator may confiscate food stamps,
39.27 authorization to purchase cards, or other assistance transaction devices found in the
39.28 possession of any person who is neither a recipient of the food stamp program nor
39.29 otherwise authorized to possess and use such materials. Confiscated property shall be
39.30 disposed of as the commissioner may direct and consistent with state and federal food
39.31 stamp law. The confiscated property must be retained for a period of not less than 30 days
39.32 to allow any affected person to appeal the confiscation under section 256.045.

39.33 (e) ~~Food stamp overpayment claims which are due in whole or in part to client~~
39.34 ~~error shall be established by the county agency for a period of six years from the date of~~
39.35 ~~any resultant overpayment.~~ <u>Establishment of a food stamp overpayment is limited to 12</u>
39.36 <u>months prior to the month of discovery due to an agency error and six years prior to the</u>

40.1 month of discovery due to a client error or an intentional program violation determined
40.2 under section 256.046.

40.3 (f) With regard to the federal tax revenue offset program only, recovery incentives
40.4 authorized by the federal food and consumer service shall be retained at the rate of 50
40.5 percent by the state agency and 50 percent by the certifying county agency.

40.6 (g) A peace officer, welfare fraud investigator, federal law enforcement official,
40.7 or the commissioner of health may confiscate vouchers found in the possession of any
40.8 person who is neither issued vouchers under sections 145.891 to 145.897, nor otherwise
40.9 authorized to possess and use such vouchers. Confiscated property shall be disposed of
40.10 as the commissioner of health may direct and consistent with state and federal law. The
40.11 confiscated property must be retained for a period of not less than 30 days.

40.12 (h) The commissioner of human services may seek a waiver from the United States
40.13 Department of Agriculture to allow the state to specify foods that may and may not be
40.14 purchased in Minnesota with benefits funded by the federal Food Stamp Program. The
40.15 commissioner shall consult with the members of the house of representatives and senate
40.16 policy committees having jurisdiction over food support issues in developing the waiver.
40.17 The commissioner, in consultation with the commissioners of health and education, shall
40.18 develop a broad public health policy related to improved nutrition and health status. The
40.19 commissioner must seek legislative approval prior to implementing the waiver.

40.20 Sec. 22. **AMERICAN INDIAN CHILD WELFARE PROJECTS.**

40.21 Notwithstanding Minnesota Statutes, section 16A.28, the commissioner of human
40.22 services shall extend payment of state fiscal year 2009 funds in state fiscal year 2010
40.23 to tribes participating in the American Indian child welfare projects under Minnesota
40.24 Statutes, section 256.01, subdivision 14b. Future extensions of payment for a tribe
40.25 participating in the Indian child welfare projects under Minnesota Statutes, section 256.01,
40.26 subdivision 14b, must be granted according to the commissioner's authority under
40.27 Minnesota Statutes, section 16A.28.

40.28 Sec. 23. **REPEALER.**

40.29 (a) Minnesota Statutes 2008, sections 256D.46; 256I.06, subdivision 9; and
40.30 256J.626, subdivision 7, are repealed.

40.31 (b) Minnesota Rules, parts 9500.1243, subpart 3; and 9500.1261, subparts 3, 4, 5,
40.32 and 6, are repealed.

41.1 **ARTICLE 3**

41.2 **CHILD SUPPORT**

41.3 Section 1. Minnesota Statutes 2008, section 518A.53, subdivision 1, is amended to
41.4 read:

41.5 Subdivision 1. **Definitions.** (a) For the purpose of this section, the following terms
41.6 have the meanings provided in this subdivision unless otherwise stated.

41.7 (b) "Payor of funds" means any person or entity that provides funds to an obligor,
41.8 including an employer as defined under chapter 24 of the Internal Revenue Code,
41.9 section 3401(d), an independent contractor, payor of worker's compensation benefits or
41.10 unemployment benefits, or a financial institution as defined in section 13B.06.

41.11 (c) "Business day" means a day on which state offices are open for regular business.

41.12 (d) The term "arrears" ~~means amounts owed under a support order that are past due~~
41.13 as used in this section has the meaning provided in section 518A.26.

41.14 **EFFECTIVE DATE.** This section is effective April 1, 2010.

41.15 Sec. 2. Minnesota Statutes 2008, section 518A.53, subdivision 4, is amended to read:

41.16 Subd. 4. **Collection services.** (a) The commissioner of human services shall prepare
41.17 and make available to the courts a notice of services that explains child support and
41.18 maintenance collection services available through the public authority, including income
41.19 withholding, and the fees for such services. Upon receiving a petition for dissolution of
41.20 marriage or legal separation, the court administrator shall promptly send the notice of
41.21 services to the petitioner and respondent at the addresses stated in the petition.

41.22 (b) Either the obligee or obligor may at any time apply to the public authority for
41.23 either full IV-D services or for income withholding only services.

41.24 (c) For those persons applying for income withholding only services, a monthly
41.25 service fee of $15 must be charged to the obligor. This fee is in addition to the amount of
41.26 the support order and shall be withheld through income withholding. The public authority
41.27 shall explain the service options in this section to the affected parties and encourage the
41.28 application for full child support collection services.

41.29 (d) If the obligee is not a current recipient of public assistance as defined in section
41.30 256.741, the person who applied for services may at any time choose to terminate either
41.31 full IV-D services or income withholding only services regardless of whether income
41.32 withholding is currently in place. The obligee or obligor may reapply for either full IV-D
41.33 services or income withholding only services at any time. Unless the applicant is a

42.1 recipient of public assistance as defined in section 256.741, a $25 application fee shall be
42.2 charged at the time of each application.

42.3 (e) When a person terminates IV-D services, if an arrearage for public assistance as
42.4 defined in section 256.741 exists, the public authority may continue income withholding,
42.5 as well as use any other enforcement remedy for the collection of child support, until all
42.6 public assistance arrears are paid in full. Income withholding shall be in an amount equal
42.7 to 20 percent of the support order in effect at the time the services terminated., unless the
42.8 support order includes a specific monthly payback amount. If the support order includes a
42.9 specific monthly payback amount, income withholding shall be in the specific amount
42.10 ordered. The provisions of this paragraph apply to all support orders in effect on or before
42.11 April 1, 2010, and to all support orders in effect after April 1, 2010.

42.12 **EFFECTIVE DATE.** This section is effective April 1, 2010.

42.13 Sec. 3. Minnesota Statutes 2008, section 518A.53, subdivision 10, is amended to read:
42.14 Subd. 10. **Arrearage order.** (a) This section does not prevent the court from
42.15 ordering the payor of funds to withhold amounts to satisfy the obligor's previous arrearage
42.16 in support order payments. This remedy shall not operate to exclude availability of other
42.17 remedies to enforce judgments. The employer or payor of funds shall withhold from
42.18 the obligor's income an additional amount equal to 20 percent of the monthly child
42.19 support or maintenance obligation until the arrearage is paid., unless the support order
42.20 includes a specific monthly payback amount. If the support order includes a specific
42.21 monthly payback amount, income withholding shall be in the specific amount ordered.
42.22 The provisions of this paragraph apply to all support orders in effect on or before April 1,
42.23 2010, and to all support orders in effect after April 1, 2010.

42.24 (b) Notwithstanding any law to the contrary, funds from income sources included
42.25 in section 518A.26, subdivision 8, whether periodic or lump sum, are not exempt from
42.26 attachment or execution upon a judgment for child support arrearage.

42.27 (c) Absent an order to the contrary, if an arrearage exists at the time a support
42.28 order would otherwise terminate, income withholding shall continue in effect or may be
42.29 implemented in an amount equal to the support order plus an additional 20 percent of the
42.30 monthly child support obligation, until all arrears have been paid in full.

42.31 **EFFECTIVE DATE.** This section is effective April 1, 2010.

43.1 **ARTICLE 4**
43.2 **STATE-OPERATED SERVICES**

43.3 Section 1. Minnesota Statutes 2008, section 246.50, subdivision 5, is amended to read:
43.4 Subd. 5. **Cost of care.** "Cost of care" means the commissioner's charge for services
43.5 provided to any person admitted to a state facility.
43.6 For purposes of this subdivision, "charge for services" means the ~~cost of services,~~
43.7 ~~treatment, maintenance, bonds issued for capital improvements, depreciation of buildings~~
43.8 ~~and equipment, and indirect costs related to the operation of state facilities. The~~
43.9 ~~commissioner may determine the charge for services on an anticipated average per diem~~
43.10 ~~basis as an all inclusive charge per facility, per disability group, or per treatment program.~~
43.11 ~~The commissioner may determine a charge per service, using a method that includes direct~~
43.12 ~~and indirect costs.~~ usual and customary fee charged for services provided to clients. The
43.13 usual and customary fee shall be established in a manner required to appropriately bill
43.14 services to all payers and shall include the costs related to the operations of any program
43.15 offered by the state.

43.16 Sec. 2. Minnesota Statutes 2008, section 246.50, is amended by adding a subdivision
43.17 to read:
43.18 Subd. 10. **State-operated community-based program.** "State-operated
43.19 community-based program" means any program operated in the community including
43.20 community behavioral health hospitals, crisis centers, residential facilities, outpatient
43.21 services, and other community-based services developed and operated by the state and
43.22 under the commissioner's control.

43.23 Sec. 3. Minnesota Statutes 2008, section 246.50, is amended by adding a subdivision
43.24 to read:
43.25 Subd. 11. **Health plan company.** "Health plan company" has the meaning given it
43.26 in section 62Q.01, subdivision 4, and also includes a demonstration provider as defined in
43.27 section 256B.69, subdivision 2, paragraph (b), a county or group of counties participating
43.28 in county-based purchasing according to section 256B.692, and a children's mental health
43.29 collaborative under contract to provide medical assistance for individuals enrolled in
43.30 the prepaid medical assistance and MinnesotaCare programs under sections 245.493 to
43.31 245.495.

44.1 Sec. 4. Minnesota Statutes 2008, section 246.51, is amended by adding a subdivision
44.2 to read:

44.3 Subd. 1a. **Clients in state-operated community-based programs; determination.**
44.4 For clients admitted to a state-operated community-based program, the commissioner shall
44.5 make an investigation to determine the available health plan coverage for services being
44.6 provided. If the health plan coverage requires a co-pay or deductible, or if there is no
44.7 available health plan coverage, the commission shall make an investigation as necessary
44.8 to determine, and as circumstances require redetermine, what part of the noncovered
44.9 cost of care, if any, the client is able to pay. If the client is unable to pay the uncovered
44.10 cost of care, the commissioner shall make a determination as to the ability of the client's
44.11 relatives to pay. The client and relatives shall provide the commissioner documents and
44.12 proof necessary to determine their ability to pay. Failure to provide the commissioner with
44.13 sufficient information to determine ability to pay may make the client or relatives liable
44.14 for the full cost of care until the time when sufficient information is provided. If it is
44.15 determined that the responsible party does not have the ability to pay, the commissioner
44.16 shall waive payment of the portion that exceeds ability to pay under the determination.

44.17 Sec. 5. Minnesota Statutes 2008, section 246.51, is amended by adding a subdivision
44.18 to read:

44.19 Subd. 1b. **Clients served by regional treatment centers or nursing homes;**
44.20 **determination.** For clients served in regional treatment centers or nursing homes operated
44.21 by state-operated services, the commissioner shall make investigation as necessary to
44.22 determine, and as circumstances require redetermine, what part of the cost of care, if any,
44.23 the client is able to pay. If the client is unable to pay the full cost of care, the commissioner
44.24 shall determine whether the client's relatives have the ability to pay. The client and
44.25 relatives shall provide the commissioner documents and proof necessary to determine their
44.26 ability to pay. Failure to provide the commissioner with sufficient information to determine
44.27 ability to pay may make the client or relatives liable for the full cost of care until the time
44.28 when sufficient information is provided. No parent shall be liable for the cost of care given
44.29 a client at a regional treatment center after the client has reached the age of 18 years.

44.30 Sec. 6. Minnesota Statutes 2008, section 246.511, is amended to read:

44.31 **246.511 RELATIVE RESPONSIBILITY.**

44.32 Except for chemical dependency services paid for with funds provided under chapter
44.33 254B, a client's relatives shall not, pursuant to the commissioner's authority under section
44.34 246.51, be ordered to pay more than ~~ten percent of the cost of~~ the following: (1) for

45.1 services provided in a community-based service, the noncovered cost of care as determined
45.2 under the ability to pay determination; and (2) for services provided at a regional treatment
45.3 center operated by state-operated services, 20 percent of the cost of care, unless they
45.4 reside outside the state. Parents of children in state facilities shall have their responsibility
45.5 to pay determined according to section 252.27, subdivision 2, or in rules adopted under
45.6 chapter 254B if the cost of care is paid under chapter 254B. The commissioner may
45.7 accept voluntary payments in excess of ~~ten~~ 20 percent. The commissioner may require
45.8 full payment of the full per capita cost of care in state facilities for clients whose parent,
45.9 parents, spouse, guardian, or conservator do not reside in Minnesota.

45.10 Sec. 7. Minnesota Statutes 2008, section 246.52, is amended to read:

45.11 **246.52 PAYMENT FOR CARE; ORDER; ACTION.**

45.12 The commissioner shall issue an order to the client or the guardian of the estate, if
45.13 there be one, and relatives determined able to pay requiring them to pay ~~monthly~~ to the
45.14 state of Minnesota the amounts so determined the total of which shall not exceed the full
45.15 cost of care. Such order shall specifically state the commissioner's determination and shall
45.16 be conclusive unless appealed from as herein provided. When a client or relative fails to
45.17 pay the amount due hereunder the attorney general, upon request of the commissioner,
45.18 may institute, or direct the appropriate county attorney to institute, civil action to recover
45.19 such amount.

45.20 Sec. 8. Minnesota Statutes 2008, section 246B.01, is amended by adding a subdivision
45.21 to read:

45.22 Subd. 1a. **Client.** "Client" means a person who is admitted to the Minnesota sex
45.23 offender program or subject to a court hold order under section 253B.185 for the purpose
45.24 of assessment, diagnosis, care, treatment, supervision, or other services provided by the
45.25 Minnesota sex offender program.

45.26 Sec. 9. Minnesota Statutes 2008, section 246B.01, is amended by adding a subdivision
45.27 to read:

45.28 Subd. 1b. **Client's county.** "Client's county" means the county of the client's
45.29 legal settlement for poor relief purposes at the time of commitment. If the client has no
45.30 legal settlement for poor relief in this state, it means the county of commitment, except
45.31 that when a client with no legal settlement for poor relief is committed while serving a
45.32 sentence at a penal institution, it means the county from which the client was sentenced.

46.1 Sec. 10. Minnesota Statutes 2008, section 246B.01, is amended by adding a
46.2 subdivision to read:

46.3 Subd. 2a. **Cost of care.** "Cost of care" means the commissioner's charge for housing
46.4 and treatment services provided to any person admitted to the Minnesota sex offender
46.5 program.

46.6 For purposes of this subdivision, "charge for housing and treatment services" means
46.7 the cost of services, treatment, maintenance, bonds issued for capital improvements,
46.8 depreciation of buildings and equipment, and indirect costs related to the operation of
46.9 state facilities. The commissioner may determine the charge for services on an anticipated
46.10 average per diem basis as an all-inclusive charge per facility.

46.11 Sec. 11. Minnesota Statutes 2008, section 246B.01, is amended by adding a subdivision
46.12 to read:

46.13 Subd. 2b. **Local social services agency.** "Local social services agency" means the
46.14 local social services agency of the client's county as defined in subdivision 1b and of the
46.15 county of commitment, and any other local social services agency possessing information
46.16 regarding, or requested by the commissioner to investigate, the financial circumstances
46.17 of a client.

46.18 Sec. 12. **[246B.07] PAYMENT FOR CARE AND TREATMENT:**
46.19 **DETERMINATION.**

46.20 Subdivision 1. **Procedures.** The commissioner shall make investigation as
46.21 necessary to determine, and as circumstances require redetermine, what part of the cost of
46.22 care, if any, the client is able to pay. The client shall provide the commissioner documents
46.23 and proof necessary to determine the ability to pay. Failure to provide the commissioner
46.24 with sufficient information to determine ability to pay may make the client liable for the
46.25 full cost of care until the time when sufficient information is provided.

46.26 Subd. 2. **Rules.** The commissioner shall adopt, pursuant to the Administrative
46.27 Procedure Act, rules establishing uniform standards for determination of client liability
46.28 for care provided by the Minnesota sex offender program. These rules shall have the
46.29 force and effect of law.

46.30 Subd. 3. **Applicability.** The commissioner may recover, under sections 246B.07 to
46.31 246B.10, the cost of any care provided by the Minnesota sex offender program.

46.32 Sec. 13. **[246B.08] PAYMENT FOR CARE; ORDER; ACTION.**

47.1 The commissioner shall issue an order to the client or the guardian of the estate, if
47.2 there is one, requiring them to pay to the state the amounts so determined, the total of which
47.3 shall not exceed the full cost of care. The order shall specifically state the commissioner's
47.4 determination and must be conclusive, unless appealed. When a client fails to pay the
47.5 amount due, the attorney general, upon request of the commissioner, may institute, or
47.6 direct the appropriate county attorney to institute, civil action to recover the amount.

47.7 Sec. 14. **[246B.09] CLAIM AGAINST ESTATE OF DECEASED CLIENT.**

47.8 Subdivision 1. **Client's estate.** Upon the death of a client, or a former client, the
47.9 total cost of care given the client, less the amount actually paid toward the cost of care by
47.10 the client, shall be filed by the commissioner as a claim against the estate of the client
47.11 with the court having jurisdiction to probate the estate and all proceeds collected by the
47.12 state in the case shall be divided between the state and county in proportion to the cost
47.13 of care each has borne.

47.14 Subd. 2. **Preferred status.** An estate claim in subdivision 1 shall be considered an
47.15 expense of the last illness for purposes of section 524.3-805.

47.16 If the commissioner of human services determines that the property or estate of a
47.17 client is not more than needed to care for and maintain the spouse and minor or dependent
47.18 children of a deceased client, the commissioner has the power to compromise the claim of
47.19 the state in a manner deemed just and proper.

47.20 Subd. 3. **Exception from statute of limitations.** Any statute of limitations that
47.21 limits the commissioner in recovering the cost of care obligation incurred by a client or
47.22 former client must not apply to any claim against an estate made under this section to
47.23 recover cost of care.

47.24 Sec. 15. **[246B.10] LIABILITY OF COUNTY; REIMBURSEMENT.**

47.25 The client's county shall pay to the state a portion of the cost of care provided in
47.26 the Minnesota sex offender program to a client legally settled in that county. A county's
47.27 payment shall be made from the county's own sources of revenue and payments shall
47.28 equal ten percent of the cost of care, as determined by the commissioner, for each day or
47.29 portion of a day, that the client spends at the facility. If payments received by the state
47.30 under sections 246.50 to 246.53 exceed 90 percent of the cost of care, the county shall
47.31 be responsible for paying the state only the remaining amount. The county shall not be
47.32 entitled to reimbursement from the client, the client's estate, or from the client's relatives,
47.33 except as provided in section 246B.07.

Sec. 16. **REPEALER.**

Minnesota Statutes 2008, sections 246.51, subdivision 1; and 246.53, subdivision 3, are repealed.

ARTICLE 5
DEPARTMENT OF HEALTH AND HEALTH CARE

Section 1. Minnesota Statutes 2008, section 13.465, subdivision 8, is amended to read:

Subd. 8. **Adoption records.** Various adoption records are classified under section 259.53, subdivision 1. Access to the original birth record of a person who has been adopted is governed by section ~~259.89~~ 144.2253.

EFFECTIVE DATE. This section is effective August 1, 2010.

Sec. 2. Minnesota Statutes 2008, section 62J.495, is amended to read:

62J.495 HEALTH INFORMATION TECHNOLOGY AND INFRASTRUCTURE.

Subdivision 1. **Implementation.** By January 1, 2015, all hospitals and health care providers must have in place an interoperable electronic health records system within their hospital system or clinical practice setting. The commissioner of health, in consultation with the e-Health ~~Information Technology and Infrastructure~~ Advisory Committee, shall develop a statewide plan to meet this goal, including uniform standards to be used for the interoperable system for sharing and synchronizing patient data across systems. The standards must be compatible with federal efforts. The uniform standards must be developed by January 1, 2009, ~~with a status report on the development of these standards submitted to the legislature by January 15, 2008~~ and updated on an ongoing basis. The commissioner shall include an update on standards development as part of an annual report to the legislature.

Subd. 1a. **Definitions.** (a) "Certified electronic health record technology" means an electronic health record that is certified pursuant to section 3001(c)(5) of the HITECH Act to meet the standards and implementation specifications adopted under section 3004 as applicable.

(b) "Commissioner" means the commissioner of health.

(c) "Pharmaceutical electronic data intermediary" means any entity that provides the infrastructure to connect computer systems or other electronic devices utilized by prescribing practitioners with those used by pharmacies, health plans, third party administrators, and pharmacy benefit manager in order to facilitate the secure transmission

49.1 of electronic prescriptions, refill authorization requests, communications, and other
49.2 prescription-related information between such entities.
49.3 (d) "HITECH Act" means the Health Information Technology for Economic and
49.4 Clinical Health Act in division A, title XIII and division B, title IV of the American
49.5 Recovery and Reinvestment Act of 2009, including federal regulations adopted under
49.6 that act.
49.7 (e) "Interoperable electronic health record" means an electronic health record that
49.8 securely exchanges health information with another electronic health record system that
49.9 meets national requirements for certification under the HITECH Act.
49.10 (f) "Qualified electronic health record" means an electronic record of health-related
49.11 information on an individual that includes patient demographic and clinical health
49.12 information and has the capacity to:
49.13 (1) provide clinical decision support;
49.14 (2) support physician order entry;
49.15 (3) capture and query information relevant to health care quality; and
49.16 (4) exchange electronic health information with, and integrate such information
49.17 from, other sources.
49.18 Subd. 2. **E-Health ~~Information Technology and Infrastructure~~ Advisory**
49.19 **Committee.** (a) The commissioner shall establish ~~a~~ an e-Health ~~Information Technology~~
49.20 ~~and Infrastructure~~ Advisory Committee governed by section 15.059 to advise the
49.21 commissioner on the following matters:
49.22 (1) assessment of the adoption and effective use of health information technology by
49.23 the state, licensed health care providers and facilities, and local public health agencies;
49.24 (2) recommendations for implementing a statewide interoperable health information
49.25 infrastructure, to include estimates of necessary resources, and for determining standards
49.26 for ~~administrative~~ clinical data exchange, clinical support programs, patient privacy
49.27 requirements, and maintenance of the security and confidentiality of individual patient
49.28 data;
49.29 (3) recommendations for encouraging use of innovative health care applications
49.30 using information technology and systems to improve patient care and reduce the cost
49.31 of care, including applications relating to disease management and personal health
49.32 management that enable remote monitoring of patients' conditions, especially those with
49.33 chronic conditions; and
49.34 (4) other related issues as requested by the commissioner.
49.35 (b) The members of the e-Health ~~Information Technology and Infrastructure~~
49.36 Advisory Committee shall include the commissioners, or commissioners' designees, of

50.1 health, human services, administration, and commerce and additional members to be
50.2 appointed by the commissioner to include persons representing Minnesota's local public
50.3 health agencies, licensed hospitals and other licensed facilities and providers, private
50.4 purchasers, the medical and nursing professions, health insurers and health plans, the
50.5 state quality improvement organization, academic and research institutions, consumer
50.6 advisory organizations with an interest and expertise in health information technology, and
50.7 other stakeholders as identified by the ~~Health Information Technology and Infrastructure~~
50.8 ~~Advisory Committee~~ commissioner to fulfill the requirements of section 3013, paragraph
50.9 (g) of the HITECH Act.

50.10 (c) The commissioner shall prepare and issue an annual report not later than January
50.11 30 of each year outlining progress to date in implementing a statewide health information
50.12 infrastructure and recommending ~~future projects~~ action on policy and necessary resources
50.13 to continue the promotion of adoption and effective use of health information technology.

50.14 (d) Notwithstanding section 15.059, this subdivision expires June 30, 2015.

50.15 Subd. 3. **Interoperable electronic health record requirements.** ~~(a)~~ To meet the
50.16 requirements of subdivision 1, hospitals and health care providers must meet the following
50.17 criteria when implementing an interoperable electronic health records system within their
50.18 hospital system or clinical practice setting.

50.19 (a) The electronic health record must be a qualified electronic health record.

50.20 (b) The electronic health record must be certified by the ~~Certification Commission~~
50.21 ~~for Healthcare Information Technology, or its successor~~ Office of the National Coordinator
50.22 pursuant to the HITECH Act. This criterion only applies to hospitals and health care
50.23 providers ~~whose practice setting is a practice setting covered by the Certification~~
50.24 ~~Commission for Healthcare Information Technology certifications~~ only if a certified
50.25 electronic health record product for the provider's particular practice setting is available.
50.26 This criterion shall be considered met if a hospital or health care provider is using an
50.27 electronic health records system that has been certified within the last three years, even if a
50.28 more current version of the system has been certified within the three-year period.

50.29 (c) The electronic health record must meet the standards established according to
50.30 section 3004 of the HITECH Act as applicable.

50.31 (d) The electronic health record must have the ability to generate information on
50.32 clinical quality measures and other measures reported under sections 4101, 4102, and
50.33 4201 of the HITECH Act.

50.34 ~~(c)~~ (e) A health care provider who is a prescriber or dispenser of ~~controlled~~
50.35 ~~substances~~ legend drugs must have an electronic health record system that meets the
50.36 requirements of section 62J.497.

51.1 Subd. 4. **Coordination with national HIT activities.** (a) The commissioner,
51.2 in consultation with the e-Health Advisory Committee, shall update the statewide
51.3 implementation plan required under subdivision 2 and released June 2008, to be consistent
51.4 with the updated Federal HIT Strategic Plan released by the Office of the National
51.5 Coordinator in accordance with section 3001 of the HITECH Act. The statewide plan
51.6 shall meet the requirements for a plan required under section 3013 of the HITECH Act.

51.7 (b) The commissioner, in consultation with the e-Health Advisory Committee, shall
51.8 work to ensure coordination between state, regional, and national efforts to support and
51.9 accelerate efforts to effectively use health information technology to improve the quality
51.10 and coordination of health care and continuity of patient care among health care providers,
51.11 to reduce medical errors, to improve population health, to reduce health disparities, and
51.12 to reduce chronic disease. The commissioner's coordination efforts shall include but not
51.13 be limited to:

51.14 (1) assisting in the development and support of health information technology
51.15 regional extension centers established under section 3012(c) of the HITECH Act to
51.16 provide technical assistance and disseminate best practices; and

51.17 (2) providing supplemental information to the best practices gathered by regional
51.18 centers to ensure that the information is relayed in a meaningful way to the Minnesota
51.19 health care community.

51.20 (c) The commissioner, in consultation with the e-Health Advisory Committee, shall
51.21 monitor national activity related to health information technology and shall coordinate
51.22 statewide input on policy development. The commissioner shall coordinate statewide
51.23 responses to proposed federal health information technology regulations in order to ensure
51.24 that the needs of the Minnesota health care community are adequately and efficiently
51.25 addressed in the proposed regulations. The commissioner's responses may include, but
51.26 are not limited to:

51.27 (1) reviewing and evaluating any standard, implementation specification, or
51.28 certification criteria proposed by the national HIT standards committee;

51.29 (2) reviewing and evaluating policy proposed by the national HIT policy
51.30 committee relating to the implementation of a nationwide health information technology
51.31 infrastructure;

51.32 (3) monitoring and responding to activity related to the development of quality
51.33 measures and other measures as required by section 4101 of the HITECH Act. Any
51.34 response related to quality measures shall consider and address the quality efforts required
51.35 under chapter 62U; and

52.1 (4) monitoring and responding to national activity related to privacy, security, and
52.2 data stewardship of electronic health information and individually identifiable health
52.3 information.

52.4 (d) To the extent that the state is either required or allowed to apply, or designate an
52.5 entity to apply for or carry out activities and programs under section 3013 of the HITECH
52.6 Act, the commissioner of health, in consultation with the e-Health Advisory Committee
52.7 and the commissioner of human services, shall be the lead applicant or sole designating
52.8 authority. The commissioner shall make such designations consistent with the goals and
52.9 objectives of sections 62J.495 to 62J.497, and sections 62J.50 to 62J.61.

52.10 (e) The commissioner of human services shall apply for funding necessary to
52.11 administer the incentive payments to providers authorized under title IV of the American
52.12 Recovery and Reinvestment Act.

52.13 (f) The commissioner shall include in the report to the legislature information on the
52.14 activities of this subdivision and provide recommendations on any relevant policy changes
52.15 that should be considered in Minnesota.

52.16 Subd. 5. **Collection of data for assessment and eligibility determination.** (a)
52.17 The commissioner of health, in consultation with the commissioner of human services,
52.18 may require providers, dispensers, group purchasers, and pharmaceutical electronic data
52.19 intermediaries to submit data in a form and manner specified by the commissioner to
52.20 assess the status of adoption, effective use, and interoperability of electronic health
52.21 records for the purpose of:

52.22 (1) demonstrating Minnesota's progress on goals established by the Office of the
52.23 National Coordinator to accelerate the adoption and effective use of health information
52.24 technology established under the HITECH Act;

52.25 (2) assisting the Center for Medicare and Medicaid Services and Department of
52.26 Human Services in determining eligibility of health care professionals and hospitals
52.27 to receive federal incentives for the adoption and effective use of health information
52.28 technology under the HITECH Act or other federal incentive programs;

52.29 (3) assisting the Office of the National Coordinator in completing required
52.30 assessments of the impact of the implementation and effective use of health information
52.31 technology in achieving goals identified in the national strategic plan, and completing
52.32 studies required by the HITECH Act;

52.33 (4) providing the data necessary to assist the Office of the National Coordinator in
52.34 conducting evaluations of regional extension centers as required by the HITECH Act; and

52.35 (5) other purposes as necessary to support the implementation of the HITECH Act.

53.1 (b) The commissioner shall coordinate with the commissioner of human services
53.2 and other state agencies in the collection of data required under this section to:
53.3 (1) avoid duplicative reporting requirements;
53.4 (2) maximize efficiencies in the development of reports on state activities as
53.5 required by HITECH; and
53.6 (3) determine health professional and hospital eligibility for incentives available
53.7 under the HITECH Act.
53.8 Subd. 6. **Data classification.** (a) Data collected on providers, dispensers, group
53.9 purchasers, and electronic data intermediaries under this section are private data on
53.10 individuals or nonpublic data, as defined in section 13.02. Notwithstanding the definition
53.11 of summary data in section 13.02, subdivision 19, summary data prepared under this
53.12 subdivision may be derived from nonpublic data.
53.13 (b) Nothing in this section authorizes the collection of individual patient data.

53.14 Sec. 3. Minnesota Statutes 2008, section 62J.496, is amended to read:

53.15 **62J.496 ELECTRONIC HEALTH RECORD SYSTEM REVOLVING**
53.16 **ACCOUNT AND LOAN PROGRAM.**

53.17 Subdivision 1. **Account establishment.** (a) An account is established to: ~~provide~~
53.18 ~~loans to eligible borrowers to assist in financing the installation or support of an~~
53.19 ~~interoperable health record system. The system must provide for the interoperable~~
53.20 ~~exchange of health care information between the applicant and, at a minimum, a hospital~~
53.21 ~~system, pharmacy, and a health care clinic or other physician group.~~
53.22 (1) finance the purchase of certified electronic health records or qualified electronic
53.23 health records as defined in section 62J.495, subdivision 1a;
53.24 (2) enhance the utilization of electronic health record technology, which may include
53.25 costs associated with upgrading the technology to meet the criteria necessary to be a
53.26 certified electronic health record or a qualified electronic health record;
53.27 (3) train personnel in the use of electronic health record technology; and
53.28 (4) improve the secure electronic exchange of health information.
53.29 (b) Amounts deposited in the account, including any grant funds obtained through
53.30 federal or other sources, loan repayments, and interest earned on the amounts shall be
53.31 used only for awarding loans or loan guarantees, as a source of reserve and security for
53.32 leveraged loans, or for the administration of the account.
53.33 (c) The commissioner may accept contributions to the account from private sector
53.34 entities subject to the following provisions:

54.1 (1) the contributing entity may not specify the recipient or recipients of any loan
54.2 issued under this subdivision;
54.3 (2) the commissioner shall make public the identity of any private contributor to the
54.4 loan fund, as well as the amount of the contribution provided; and
54.5 (3) the commissioner may issue letters of commendation or make other awards that
54.6 have no financial value to any such entity.
54.7 A contributing entity may not specify that the recipient or recipients of any loan use
54.8 specific products or services, nor may the contributing entity imply that a contribution is
54.9 an endorsement of any specific product or service.
54.10 (d) The commissioner may use the loan funds to reimburse private sector entities
54.11 for any contribution made to the loan fund. Reimbursement to private entities may not
54.12 exceed the principle amount contributed to the loan fund.
54.13 (e) The commissioner may use funds deposited in the account to guarantee, or
54.14 purchase insurance for, a local obligation if the guarantee or purchase would improve
54.15 credit market access or reduce the interest rate applicable to the obligation involved.
54.16 (f) The commissioner may use funds deposited in the account as a source of revenue
54.17 or security for the payment of principal and interest on revenue or bonds issued by the
54.18 state if the proceeds of the sale of the bonds will be deposited into the loan fund.
54.19 Subd. 2. **Eligibility.** (a) "Eligible borrower" means one of the following:
54.20 (1) federally qualified health centers;
54.21 ~~(1)~~ (2) community clinics, as defined under section 145.9268;
54.22 ~~(2)~~ (3) nonprofit hospitals ~~eligible for rural hospital capital improvement grants, as~~
54.23 ~~defined in section 144.148~~ licensed under sections 144.50 to 144.56;
54.24 ~~(3) physician clinics located in a community with a population of less than 50,000~~
54.25 ~~according to United States Census Bureau statistics and outside the seven-county~~
54.26 ~~metropolitan area;~~
54.27 (4) individual or small group physician practices that are focused primarily on
54.28 primary care;
54.29 ~~(4)~~ (5) nursing facilities licensed under sections 144A.01 to 144A.27; ~~and~~
54.30 (6) local public health departments as defined in chapter 145A; and
54.31 ~~(5)~~ (7) other providers of health or health care services approved by the
54.32 commissioner for which interoperable electronic health record capability would improve
54.33 quality of care, patient safety, or community health.
54.34 (b) The commissioner shall administer the loan fund to prioritize support and
54.35 assistance to:
54.36 (1) critical access hospitals;

55.1 (2) federally qualified health centers;
55.2 (3) entities that serve uninsured, underinsured, and medically underserved
55.3 individuals, regardless of whether such area is urban or rural; and
55.4 (4) individual or small group practices that are primarily focused on primary care.
55.5 ~~(b) To be eligible for a loan under this section, the~~ (c) An eligible applicant must
55.6 submit a loan application to the commissioner of health on forms prescribed by the
55.7 commissioner. The application must include, at a minimum:
55.8 (1) the amount of the loan requested and a description of the purpose or project
55.9 for which the loan proceeds will be used;
55.10 (2) a quote from a vendor;
55.11 (3) a description of the health care entities and other groups participating in the
55.12 project;
55.13 (4) evidence of financial stability and a demonstrated ability to repay the loan; and
55.14 (5) a description of how the system to be financed ~~interconnects~~ interoperates or
55.15 plans in the future to ~~interconnect~~ interoperate with other health care entities and provider
55.16 groups located in the same geographical area;
55.17 (6) a plan on how the certified electronic health record technology will be maintained
55.18 and supported over time; and
55.19 (7) any other requirements for applications included or developed pursuant to
55.20 section 3014 of the HITECH Act.
55.21 Subd. 3. **Loans and grants.** (a) The commissioner of health may make a ~~no interest~~
55.22 grant, or a no interest loan or low interest loan to a provider or provider group who is
55.23 eligible under subdivision 2 ~~on a first-come, first-served basis provided that the applicant~~
55.24 ~~is able to comply with this section~~ consistent with the priorities established in subdivision
55.25 2. The total accumulative loan principal must not exceed ~~$1,500,000~~ $3,000,000 per loan.
55.26 The interest rate for each loan, if imposed, shall not exceed the current market interest
55.27 rate. The commissioner of health has discretion over the size, interest rate, and number
55.28 of loans made. Nothing in this section shall require the commissioner to make a loan to
55.29 an eligible borrower under subdivision 2.
55.30 (b) The commissioner of health may prescribe forms and establish an application
55.31 process and, notwithstanding section 16A.1283, may impose a reasonable nonrefundable
55.32 application fee to cover the cost of administering the loan program. Any application
55.33 fees imposed and collected under the electronic health records system revolving account
55.34 and loan program in this section are appropriated to the commissioner of health for the
55.35 duration of the loan program. The commissioner may apply for and use all federal funds
55.36 available through the HITECH Act to administer the loan program.

56.1 (c) For loans approved prior to July 1, 2009, the borrower must begin repaying the
56.2 principal no later than two years from the date of the loan. Loans must be amortized no
56.3 later than six years from the date of the loan.

56.4 (d) For loans granted on January 1, 2010, or thereafter, the borrower must begin
56.5 repaying the principle no later than one year from the date of the loan. Loans must be
56.6 amortized no later than six years after the date of the loan.

56.7 ~~(d) Repayments~~ (e) All repayments and interest paid on each loan must be credited
56.8 to the account.

56.9 (f) The loan agreement shall include the assurances that borrower meets requirements
56.10 included or developed pursuant to section 3014 of the HITECH Act. The requirements
56.11 shall include, but are not limited to:

56.12 (1) submitting reports on quality measures in compliance with regulations adopted
56.13 by the federal government;

56.14 (2) demonstrating that any certified electronic health record technology purchased,
56.15 improved, or otherwise financially supported by this loan program is used to exchange
56.16 health information in a manner that, in accordance with law and standards applicable to
56.17 the exchange of information, improves the quality of health care;

56.18 (3) including a plan on how the borrower intends to maintain and support the
56.19 certified electronic health record technology over time and the resources expected to be
56.20 used to maintain and support the technology purchased with the loan; and

56.21 (4) complying with other requirements the secretary may require to use loans funds
56.22 under the HITECH Act.

56.23 Subd. 4. **Data classification.** Data collected by the commissioner of health on the
56.24 application to determine eligibility under subdivision 2 and to monitor borrowers' default
56.25 risk or collect payments owed under subdivision 3 are (1) private data on individuals as
56.26 defined in section 13.02, subdivision 12; and (2) nonpublic data as defined in section
56.27 13.02, subdivision 9. The names of borrowers and the amounts of the loans granted
56.28 are public data.

56.29 Sec. 4. Minnesota Statutes 2008, section 62J.497, subdivision 1, is amended to read:

56.30 Subdivision 1. **Definitions.** For the purposes of this section, the following terms
56.31 have the meanings given.

56.32 (a) "Backward compatible" means that the newer version of a data transmission
56.33 standard would retain, at a minimum, the full functionality of the versions previously
56.34 adopted, and would permit the successful completion of the applicable transactions with
56.35 entities that continue to use the older versions.

~~(a)~~ (b) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

~~(b)~~ (c) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription.

~~(c)~~ (d) "Electronic media" has the meaning given under Code of Federal Regulations, title 45, part 160.103.

~~(d)~~ (e) "E-prescribing" means the transmission using electronic media of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or group purchaser, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser and two-way transmissions related to eligibility, formulary, and medication history information.

~~(e)~~ (f) "Electronic prescription drug program" means a program that provides for e-prescribing.

~~(f)~~ (g) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

~~(g)~~ (h) "HL7 messages" means a standard approved by the standards development organization known as Health Level Seven.

~~(h)~~ (i) "National Provider Identifier" or "NPI" means the identifier described under Code of Federal Regulations, title 45, part 162.406.

~~(i)~~ (j) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

~~(j)~~ (k) "NCPDP Formulary and Benefits Standard" means the National Council for Prescription Drug Programs Formulary and Benefits Standard, Implementation Guide, Version 1, Release 0, October 2005.

~~(k)~~ (l) "NCPDP SCRIPT Standard" means the National Council for Prescription Drug Programs Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide Version 8, Release 1 (Version 8.1), October 2005, or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance. Subsequently released versions of the NCPDP SCRIPT Standard may be used, provided that the new version of the standard is backward compatible to the current version adopted by the Centers for Medicare and Medicaid Services.

~~(l)~~ (m) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

~~(m)~~ (n) "Prescriber" means a licensed health care ~~professional who is authorized to prescribe a controlled substance under section 152.12, subdivision 1.~~ practitioner, other than a veterinarian, as defined in section 151.01, subdivision 23.

~~(n)~~ (o) "Prescription-related information" means information regarding eligibility for drug benefits, medication history, or related health or drug information.

~~(o)~~ (p) "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

Sec. 5. Minnesota Statutes 2008, section 62J.497, subdivision 2, is amended to read:

Subd. 2. **Requirements for electronic prescribing.** (a) Effective January 1, 2011, all providers, group purchasers, prescribers, and dispensers must establish ~~and~~, maintain, and use an electronic prescription drug program ~~that complies~~. This program must comply with the applicable standards in this section for transmitting, directly or through an intermediary, prescriptions and prescription-related information using electronic media.

(b) ~~Nothing in this section requires providers, group purchasers, prescribers, or dispensers to conduct the transactions described in this section.~~ If transactions described in this section are conducted, they must be done electronically using the standards described in this section. Nothing in this section requires providers, group purchasers, prescribers, or dispensers to electronically conduct transactions that are expressly prohibited by other sections or federal law.

(c) Providers, group purchasers, prescribers, and dispensers must use either HL7 messages or the NCPDP SCRIPT Standard to transmit prescriptions or prescription-related information internally when the sender and the recipient are part of the same legal entity. If an entity sends prescriptions outside the entity, it must use the NCPDP SCRIPT Standard or other applicable standards required by this section. Any pharmacy within an entity must be able to receive electronic prescription transmittals from outside the entity using the adopted NCPDP SCRIPT Standard. This exemption does not supersede any Health Insurance Portability and Accountability Act (HIPAA) requirement that may require the use of a HIPAA transaction standard within an organization.

~~(d) Entities transmitting prescriptions or prescription-related information where the prescriber is required by law to issue a prescription for a patient to a nonprescribing provider that in turn forwards the prescription to a dispenser are exempt from the requirement to use the NCPDP SCRIPT Standard when transmitting prescriptions or prescription-related information.~~

59.1 Sec. 6. Minnesota Statutes 2008, section 62J.497, is amended by adding a subdivision
59.2 to read:

59.3 Subd. 4. **Development and use of uniform formulary exception form.** (a) The
59.4 commissioner of health, in consultation with the Minnesota Administrative Uniformity
59.5 Committee, shall develop by July 1, 2009, or six weeks after enactment of this subdivision,
59.6 whichever is later, a uniform formulary exception form that allows health care providers
59.7 to request exceptions from group purchaser formularies using a uniform form. Upon
59.8 development of the form, all health care providers must submit requests for formulary
59.9 exceptions using the uniform form, and all group purchasers must accept this form from
59.10 health care providers.

59.11 (b) No later than January 1, 2011, the uniform formulary exception form must be
59.12 accessible and submitted by health care providers, and accepted and processed by group
59.13 purchasers, through secure electronic transmissions. Facsimile shall not be considered
59.14 secure electronic transmissions.

59.15 Sec. 7. Minnesota Statutes 2008, section 62J.497, is amended by adding a subdivision
59.16 to read:

59.17 Subd. 5. **Electronic drug prior authorization standardization and transmission.**
59.18 (a) The commissioner of health, in consultation with the Minnesota e-Health Advisory
59.19 Committee and the Minnesota Administrative Uniformity Committee, shall, by February
59.20 15, 2010, identify an outline on how best to standardize drug prior authorization request
59.21 transactions between providers and group purchasers with the goal of maximizing
59.22 administrative simplification and efficiency in preparation for electronic transmissions.

59.23 (b) No later than January 1, 2011, drug prior authorization requests must be
59.24 accessible and submitted by health care providers, and accepted and processed by group
59.25 purchasers, electronically through secure electronic transmissions. Facsimile shall not be
59.26 considered electronic transmission.

59.27 Sec. 8. **[62Q.676] MEDICATION THERAPY MANAGEMENT.**

59.28 A pharmacy benefit manager that provides prescription drug services must make
59.29 available medication therapy management services for enrollees taking four or more
59.30 prescriptions to treat or prevent two or more chronic medical conditions. For purposes
59.31 of this section, "medication therapy management" means the provision of the following
59.32 pharmaceutical care services by a licensed pharmacist to optimize the therapeutic
59.33 outcomes of the patient's medications:

60.1 (1) performing a comprehensive medication review to identify, resolve, and prevent
60.2 medication-related problems, including adverse drug events;
60.3 (2) communicating essential information to the patient's other primary care
60.4 providers; and
60.5 (3) providing verbal education and training designed to enhance patient
60.6 understanding and appropriate use of the patient's medications.
60.7 Nothing in this section shall be construed to expand or modify the scope of practice
60.8 of the pharmacist as defined in section 151.01, subdivision 27.

60.9 Sec. 9. Minnesota Statutes 2008, section 144.122, is amended to read:

60.10 **144.122 LICENSE, PERMIT, AND SURVEY FEES.**

60.11 (a) The state commissioner of health, by rule, may prescribe procedures and fees
60.12 for filing with the commissioner as prescribed by statute and for the issuance of original
60.13 and renewal permits, licenses, registrations, and certifications issued under authority of
60.14 the commissioner. The expiration dates of the various licenses, permits, registrations,
60.15 and certifications as prescribed by the rules shall be plainly marked thereon. Fees may
60.16 include application and examination fees and a penalty fee for renewal applications
60.17 submitted after the expiration date of the previously issued permit, license, registration,
60.18 and certification. The commissioner may also prescribe, by rule, reduced fees for permits,
60.19 licenses, registrations, and certifications when the application therefor is submitted
60.20 during the last three months of the permit, license, registration, or certification period.
60.21 Fees proposed to be prescribed in the rules shall be first approved by the Department of
60.22 Finance. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be
60.23 in an amount so that the total fees collected by the commissioner will, where practical,
60.24 approximate the cost to the commissioner in administering the program. All fees collected
60.25 shall be deposited in the state treasury and credited to the state government special revenue
60.26 fund unless otherwise specifically appropriated by law for specific purposes.

60.27 (b) The commissioner may charge a fee for voluntary certification of medical
60.28 laboratories and environmental laboratories, and for environmental and medical laboratory
60.29 services provided by the department, without complying with paragraph (a) or chapter 14.
60.30 Fees charged for environment and medical laboratory services provided by the department
60.31 must be approximately equal to the costs of providing the services.

60.32 (c) The commissioner may develop a schedule of fees for diagnostic evaluations
60.33 conducted at clinics held by the services for children with disabilities program. All
60.34 receipts generated by the program are annually appropriated to the commissioner for use
60.35 in the maternal and child health program.

(d) The commissioner shall set license fees for hospitals and nursing homes that are not boarding care homes at the following levels:

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and American Osteopathic Association (AOA) hospitals	~~$7,555~~ $7,655 plus ~~$13~~ $16 per bed
Non-JCAHO and non-AOA hospitals	~~$5,180~~ $5,280 plus ~~$247~~ $250 per bed
Nursing home	$183 plus $91 per bed

The commissioner shall set license fees for outpatient surgical centers, boarding care homes, and supervised living facilities at the following levels:

Outpatient surgical centers	~~$3,349~~ $3,712
Boarding care homes	$183 plus $91 per bed
Supervised living facilities	$183 plus $91 per bed.

(e) Unless prohibited by federal law, the commissioner of health shall charge applicants the following fees to cover the cost of any initial certification surveys required to determine a provider's eligibility to participate in the Medicare or Medicaid program:

Prospective payment surveys for hospitals	$	900
Swing bed surveys for nursing homes	$	1,200
Psychiatric hospitals	$	1,400
Rural health facilities	$	1,100
Portable x-ray providers	$	500
Home health agencies	$	1,800
Outpatient therapy agencies	$	800
End stage renal dialysis providers	$	2,100
Independent therapists	$	800
Comprehensive rehabilitation outpatient facilities	$	1,200
Hospice providers	$	1,700
Ambulatory surgical providers	$	1,800
Hospitals	$	4,200
Other provider categories or additional resurveys required to complete initial certification	Actual surveyor costs: average surveyor cost x number of hours for the survey process.	

These fees shall be submitted at the time of the application for federal certification and shall not be refunded. All fees collected after the date that the imposition of fees is not prohibited by federal law shall be deposited in the state treasury and credited to the state government special revenue fund.

Sec. 10. Minnesota Statutes 2008, section 144.218, subdivision 1, is amended to read:

Subdivision 1. **Adoption.** (a) Upon receipt of a certified copy of an order, decree, or certificate of adoption, the state registrar shall register a replacement vital record in

62.1 the new name of the adopted person. Except as provided in paragraph (b), the original
62.2 record of birth is ~~confidential pursuant to~~ private data on individuals, as defined in section
62.3 13.02, subdivision ~~3~~ 12, and shall not be disclosed except pursuant to court order or
62.4 section 144.2252 or 144.2253.

62.5 (b) The information contained on the original birth record, except for the registration
62.6 number, shall be provided on request to: (1) a parent who is named on the original birth
62.7 record; or (2) the adopted person who is the subject of the record if the person is at least
62.8 19 years of age, unless there is an affidavit of nondisclosure on file with the state registrar.
62.9 Upon the receipt of a certified copy of a court order of annulment of adoption the state
62.10 registrar shall restore the original vital record to its original place in the file.

62.11 **EFFECTIVE DATE.** This section is effective August 1, 2010.

62.12 Sec. 11. Minnesota Statutes 2008, section 144.225, subdivision 2, is amended to read:

62.13 Subd. 2. **Data about births.** (a) Except as otherwise provided in this subdivision,
62.14 data pertaining to the birth of a child to a woman who was not married to the child's father
62.15 when the child was conceived nor when the child was born, including the original record
62.16 of birth and the certified vital record, are confidential data. At the time of the birth of a
62.17 child to a woman who was not married to the child's father when the child was conceived
62.18 nor when the child was born, the mother may designate demographic data pertaining to
62.19 the birth as public. Notwithstanding the designation of the data as confidential, it may
62.20 be disclosed:

62.21 (1) to a parent or guardian of the child;

62.22 (2) to the child when the child is 16 years of age or older;

62.23 (3) under paragraph (b) or (e); or

62.24 (4) pursuant to a court order. For purposes of this section, a subpoena does not
62.25 constitute a court order.

62.26 (b) Unless the child is adopted, data pertaining to the birth of a child that are not
62.27 accessible to the public become public data if 100 years have elapsed since the birth of
62.28 the child who is the subject of the data, or as provided under section 13.10, whichever
62.29 occurs first.

62.30 (c) If a child is adopted, data pertaining to the child's birth are governed by the
62.31 provisions relating to adoption records, including sections 13.10, subdivision 5; 144.218,
62.32 subdivision 1; 144.2252; 144.2253; and 259.89.

62.33 (d) The name and address of a mother under paragraph (a) and the child's date of
62.34 birth may be disclosed to the county social services or public health member of a family
62.35 services collaborative for purposes of providing services under section 124D.23.

63.1 (e) The commissioner of human services shall have access to birth records for:
63.2 (1) the purposes of administering medical assistance, general assistance medical
63.3 care, and the MinnesotaCare program;
63.4 (2) child support enforcement purposes; and
63.5 (3) other public health purposes as determined by the commissioner of health.

63.6 **EFFECTIVE DATE.** This section is effective August 1, 2010.

63.7 Sec. 12. Minnesota Statutes 2008, section 144.2252, is amended to read:

63.8 **144.2252 ACCESS TO ORIGINAL BIRTH RECORD AFTER ADOPTION.**

63.9 (a) Whenever an adopted person requests the state registrar to disclose the
63.10 information on the adopted person's original birth record, the state registrar shall act
63.11 according to section ~~259.89~~ 144.2253.
63.12 (b) The state registrar shall provide a transcript of an adopted person's original birth
63.13 record to an authorized representative of a federally recognized American Indian tribe
63.14 for the sole purpose of determining the adopted person's eligibility for enrollment or
63.15 membership. Information contained in the birth record may not be used to provide the
63.16 adopted person information about the person's birth parents, except as provided in this
63.17 section or section ~~259.83~~ 144.2253.

63.18 **EFFECTIVE DATE.** This section is effective August 1, 2010.

63.19 Sec. 13. **[144.2253] ACCESS TO ORIGINAL BIRTH RECORDS BY ADOPTED**
63.20 **PERSON; DEPARTMENT DUTIES.**

63.21 Subdivision 1. **Affidavits.** The department shall prepare affidavit of disclosure and
63.22 nondisclosure forms under which a birth parent may agree to or object to the release of the
63.23 original birth record to the adopted person. The department shall make the forms readily
63.24 accessible to birth parents on the department's Web site.
63.25 Subd. 2. **Disclosure.** Upon request, the state registrar shall provide a noncertified
63.26 copy of the original birth record to an adopted person age 19 or older, unless there is
63.27 an affidavit of nondisclosure on file. The state registrar must comply with the terms of
63.28 affidavits of disclosure or affidavits of nondisclosure.
63.29 Subd. 3. **Rescission of affidavit.** A birth parent may rescind an affidavit of
63.30 disclosure or an affidavit of nondisclosure at any time.
63.31 Subd. 4. **Affidavit of nondisclosure; access to birth record.** If an affidavit of
63.32 nondisclosure is on file with the registrar, an adopted person age 19 or older may petition
63.33 the appropriate court for disclosure of the original birth record pursuant to section 259.61.

64.1 The court shall grant the petition if, after consideration of the interests of all known
64.2 persons affected by the petition, the court determines that the benefits of disclosure of the
64.3 information are greater than the benefits of nondisclosure.

64.4 Subd. 5. **Information provided.** (a) The department shall, in consultation with
64.5 adoption agencies and adoption advocates, provide information and educational materials
64.6 to adopted persons and birth parents about the changes in the law under this act affecting
64.7 accessibility to birth records. For purposes of this subdivision, an adoption advocate is a
64.8 nonprofit organization that works with adoption issues in Minnesota.

64.9 (b) The department shall include a notice on the department Web site about the
64.10 change in the law under this act and direct individuals to private agencies and advocates
64.11 for post-adoption resources.

64.12 (c) Adoption agencies may charge a fee for counseling and support services provided
64.13 to adopted persons and birth parents.

64.14 **EFFECTIVE DATE.** This section is effective August 1, 2010.

64.15 Sec. 14. Minnesota Statutes 2008, section 144.226, subdivision 1, is amended to read:

64.16 Subdivision 1. **Which services are for fee.** The fees for the following services shall
64.17 be the following or an amount prescribed by rule of the commissioner:

64.18 (a) The fee for the issuance of a certified vital record or a certification that the vital
64.19 record cannot be found is $9. No fee shall be charged for a certified birth, stillbirth, or
64.20 death record that is reissued within one year of the original issue, if an amendment is
64.21 made to the vital record and if the previously issued vital record is surrendered. The
64.22 fee is nonrefundable.

64.23 (b) The fee for processing a request for the replacement of a birth record for
64.24 all events, except when filing a recognition of parentage pursuant to section 257.73,
64.25 subdivision 1, is $40. The fee is payable at the time of application and is nonrefundable.

64.26 (c) The fee for processing a request for the filing of a delayed registration of
64.27 birth, stillbirth, or death is $40. The fee is payable at the time of application and is
64.28 nonrefundable. This fee includes one subsequent review of the request if the request
64.29 is not acceptable upon the initial receipt.

64.30 (d) The fee for processing a request for the amendment of any vital record when
64.31 requested more than 45 days after the filing of the vital record is $40. No fee shall be
64.32 charged for an amendment requested within 45 days after the filing of the vital record.
64.33 The fee is payable at the time of application and is nonrefundable. This fee includes one
64.34 subsequent review of the request if the request is not acceptable upon the initial receipt.

(e) The fee for processing a request for the verification of information from vital records is $9 when the applicant furnishes the specific information to locate the vital record. When the applicant does not furnish specific information, the fee is $20 per hour for staff time expended. Specific information includes the correct date of the event and the correct name of the registrant. Fees charged shall approximate the costs incurred in searching and copying the vital records. The fee is payable at the time of application and is nonrefundable.

(f) The fee for processing a request for the issuance of a copy of any document on file pertaining to a vital record or statement that a related document cannot be found is $9. The fee is payable at the time of application and is nonrefundable.

(g) The department shall charge a fee of $18 for noncertified copies of birth records provided to adopted persons age 19 or older to cover the cost of providing the birth record and any costs associated with the distribution of information to adopted persons and birth parents required under section 144.2253, subdivision 5.

EFFECTIVE DATE. This section is effective August 1, 2010.

Sec. 15. Minnesota Statutes 2008, section 144.226, subdivision 4, is amended to read:

Subd. 4. **Vital records surcharge.** (a) In addition to any fee prescribed under subdivision 1, there is a nonrefundable surcharge of $2 for each certified and noncertified birth, stillbirth, or death record, and for a certification that the record cannot be found. The local or state registrar shall forward this amount to the commissioner of finance to be deposited into the state government special revenue fund. This surcharge shall not be charged under those circumstances in which no fee for a birth, stillbirth, or death record is permitted under subdivision 1, paragraph (a).

(b) Effective August 1, 2005, ~~to June 30, 2009,~~ the surcharge in paragraph (a) ~~shall be~~ is $4.

Sec. 16. Minnesota Statutes 2008, section 148.6445, is amended by adding a subdivision to read:

Subd. 2a. **Duplicate license fee.** The fee for a duplicate license is $25.

Sec. 17. Minnesota Statutes 2008, section 259.89, subdivision 1, is amended to read:

Subdivision 1. **Request.** An adopted person who is 19 years of age or over may request the commissioner of health to disclose the information on the adopted person's original birth record. ~~The commissioner of health shall, within five days of receipt of the request, notify the commissioner of human services' agent or licensed child-placing~~

~~agency when known, or the commissioner of human services when the agency is not known in writing of the request by the adopted person.~~

EFFECTIVE DATE. This section is effective August 1, 2010.

Sec. 18. Minnesota Statutes 2008, section 260C.317, subdivision 4, is amended to read:

Subd. 4. **Rights of terminated parent.** Upon entry of an order terminating the parental rights of any person who is identified as a parent on the original birth record of the child as to whom the parental rights are terminated, the court shall cause written notice to be made to that person setting forth:

(1) the right of the person to file at any time with the state registrar of vital statistics a consent to disclosure, as defined in section 144.212, subdivision 11; and

(2) the right of the person to file at any time with the state registrar of vital statistics an affidavit stating that the information on the original birth record shall not be disclosed as provided in section ~~144.2252~~ 144.2253~~; and~~.

~~(3) the effect of a failure to file either a consent to disclosure, as defined in section 144.212, subdivision 11, or an affidavit stating that the information on the original birth record shall not be disclosed.~~

EFFECTIVE DATE. This section is effective August 1, 2010.

Sec. 19. **REPEALER.**

(a) Minnesota Statutes 2008, sections 259.83, subdivision 3; and 259.89, subdivisions 2, 3, and 4, are repealed effective August 1, 2010.

(b) Minnesota Statutes 2008, section 62U.08, is repealed.

ARTICLE 6
HEALTH CARE PROGRAMS

Section 1. Minnesota Statutes 2008, section 62J.692, subdivision 7, is amended to read:

Subd. 7. **Transfers from the commissioner of human services.** ~~(a) The amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (1), shall be distributed by the commissioner annually to clinical medical education programs that meet the qualifications of subdivision 3 based on the formula in subdivision 4, paragraph (a).~~ Of the amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clauses (1) to (4), $21,714,000 must be distributed as follows:

(1) $2,157,000 by the commissioner to the University of Minnesota Board of Regents for the purposes described in sections 137.38 to 137.40;

67.1 (2) $1,035,360 by the commissioner to the Hennepin County Medical Center for
67.2 clinical medical education;
67.3 (3) $17,400,000 by the commissioner to the University of Minnesota Board of
67.4 Regents for purposes of medical education;
67.5 (4) $1,121,640 by the commissioner to clinical medical education dental innovation
67.6 grants in accordance with subdivision 7a; and
67.7 (5) the remainder of the amount transferred according to section 256B.69,
67.8 subdivision 5c, paragraph (a), clauses (1) to (4), must be distributed by the commissioner
67.9 annually to clinical medical education programs that meet the qualifications of subdivision
67.10 3 based on the formula in subdivision 4, paragraph (a).
67.11 ~~(b) Fifty percent of the amount transferred according to section 256B.69, subdivision~~
67.12 ~~5c, paragraph (a), clause (2), shall be distributed by the commissioner to the University of~~
67.13 ~~Minnesota Board of Regents for the purposes described in sections 137.38 to 137.40. Of~~
67.14 ~~the remaining amount transferred according to section 256B.69, subdivision 5c, paragraph~~
67.15 ~~(a), clause (2), 24 percent of the amount shall be distributed by the commissioner to~~
67.16 ~~the Hennepin County Medical Center for clinical medical education. The remaining 26~~
67.17 ~~percent of the amount transferred shall be distributed by the commissioner in accordance~~
67.18 ~~with subdivision 7a. If the federal approval is not obtained for the matching funds under~~
67.19 ~~section 256B.69, subdivision 5c, paragraph (a), clause (2), 100 percent of the amount~~
67.20 ~~transferred under this paragraph shall be distributed by the commissioner to the University~~
67.21 ~~of Minnesota Board of Regents for the purposes described in sections 137.38 to 137.40.~~
67.22 ~~(c) The amount transferred according to section 256B.69, subdivision 5c, paragraph~~
67.23 ~~(a), clauses (3) and (4), shall be distributed by the commissioner upon receipt to the~~
67.24 ~~University of Minnesota Board of Regents for the purposes of clinical graduate medical~~
67.25 ~~education.~~

67.26 Sec. 2. Minnesota Statutes 2008, section 125A.744, subdivision 3, is amended to read:
67.27 Subd. 3. **Implementation.** Consistent with section 256B.0625, subdivision 26,
67.28 school districts may enroll as medical assistance providers or subcontractors and bill
67.29 the Department of Human Services under the medical assistance fee for service claims
67.30 processing system for special education services which are covered services under chapter
67.31 256B, which are provided in the school setting for a medical assistance recipient, and for
67.32 whom the district has secured informed consent consistent with section 13.05, subdivision
67.33 4, paragraph (d), and section 256B.77, subdivision 2, paragraph (p), to bill for each type
67.34 of covered service. School districts shall be reimbursed by the commissioner of human
67.35 services for the federal share of individual education plan health-related services that

qualify for reimbursement by medical assistance, minus up to five percent retained by the commissioner of human services for administrative costs~~, not to exceed $350,000 per fiscal year~~. The commissioner may withhold up to five percent of each payment to a school district. Following the end of each fiscal year, the commissioner shall settle up with each school district in order to ensure that collections from each district for departmental administrative costs are made on a pro rata basis according to federal earnings for these services in each district. A school district is not eligible to enroll as a home care provider or a personal care provider organization for purposes of billing home care services under sections 256B.0651 and 256B.0653 to 256B.0656 until the commissioner of human services issues a bulletin instructing county public health nurses on how to assess for the needs of eligible recipients during school hours. To use private duty nursing services or personal care services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school.

Sec. 3. Minnesota Statutes 2008, section 256.01, subdivision 2b, is amended to read:

Subd. 2b. **Performance payments; performance measurement.** (a) The commissioner shall develop and implement a pay-for-performance system to provide performance payments to eligible medical groups and clinics that demonstrate optimum care in serving individuals with chronic diseases who are enrolled in health care programs administered by the commissioner under chapters 256B, 256D, and 256L. The commissioner may receive any federal matching money that is made available through the medical assistance program for managed care oversight contracted through vendors, including consumer surveys, studies, and external quality reviews as required by the federal Balanced Budget Act of 1997, Code of Federal Regulations, title 42, part 438-managed care, subpart E-external quality review. Any federal money received for managed care oversight is appropriated to the commissioner for this purpose. The commissioner may expend the federal money received in either year of the biennium.

(b) ~~Effective July 1, 2008, or upon federal approval, whichever is later, the commissioner shall develop and implement a patient incentive health program to provide incentives and rewards to patients who are enrolled in health care programs administered by the commissioner under chapters 256B, 256D, and 256L, and who have agreed to and have met personal health goals established with the patients' primary care providers to manage a chronic disease or condition, including but not limited to diabetes, high blood pressure, and coronary artery disease.~~ The commissioner, in consultation with the Health and Human Services Policy Committee, shall develop and provide to the legislature by

69.1 December 15, 2009, a methodology and any draft legislation necessary to allow for the
69.2 release, upon request, of summary data as defined in section 13.02, subdivision 19,
69.3 on claims and utilization for medical assistance, general assistance medical care, and
69.4 MinnesotaCare enrollees at no charge to the University of Minnesota Medical School, the
69.5 Mayo Medical School, Northwestern Health Sciences University, the Institute for Clinical
69.6 Systems Improvement, and other research institutions, to conduct analyses of health care
69.7 outcomes and treatment effectiveness, provided the research institutions do not release
69.8 private or nonpublic data, or data for which dissemination is prohibited by law.

69.9 Sec. 4. Minnesota Statutes 2008, section 256.01, is amended by adding a subdivision
69.10 to read:
69.11 Subd. 18a. **Public Assistance Reporting Information System.** (a) Effective
69.12 October 1, 2009, the commissioner shall comply with the federal requirements in Public
69.13 Law 110-379 in implementing the Public Assistance Reporting Information System
69.14 (PARIS) to determine eligibility for all individuals applying for:
69.15 (1) health care benefits under chapters 256B, 256D, and 256L; and
69.16 (2) public benefits under chapters 119B, 256D, 256I, and the supplemental nutrition
69.17 assistance program.
69.18 (b) The commissioner shall determine eligibility under paragraph (a) by performing
69.19 data matches, including matching with medical assistance, cash, child care, and
69.20 supplemental assistance programs operated by other states.

69.21 **EFFECTIVE DATE.** This section is effective October 1, 2009.

69.22 Sec. 5. Minnesota Statutes 2008, section 256.962, subdivision 2, is amended to read:
69.23 Subd. 2. **Outreach grants.** (a) The commissioner shall award grants to public and
69.24 private organizations, regional collaboratives, and regional health care outreach centers
69.25 for outreach activities, including, but not limited to:
69.26 (1) providing information, applications, and assistance in obtaining coverage
69.27 through Minnesota public health care programs;
69.28 (2) collaborating with public and private entities such as hospitals, providers, health
69.29 plans, legal aid offices, pharmacies, insurance agencies, and faith-based organizations to
69.30 develop outreach activities and partnerships to ensure the distribution of information
69.31 and applications and provide assistance in obtaining coverage through Minnesota health
69.32 care programs; ~~and~~

70.1 (3) providing or collaborating with public and private entities to provide multilingual
70.2 and culturally specific information and assistance to applicants in areas of high
70.3 uninsurance in the state or populations with high rates of uninsurance; and
70.4 (4) targeting geographic areas with high rates of (i) eligible but unenrolled children,
70.5 including children who reside in rural areas, or (ii) racial and ethnic minorities and health
70.6 disparity populations.
70.7 (b) The commissioner shall ensure that all outreach materials are available in
70.8 languages other than English.
70.9 (c) The commissioner shall establish an outreach trainer program to provide
70.10 training to designated individuals from the community and public and private entities on
70.11 application assistance in order for these individuals to provide training to others in the
70.12 community on an as-needed basis.

70.13 Sec. 6. Minnesota Statutes 2008, section 256.962, subdivision 6, is amended to read:
70.14 Subd. 6. **School districts and charter schools.** (a) At the beginning of each school
70.15 year, a school district or charter school shall provide information to each student on the
70.16 availability of health care coverage through the Minnesota health care programs and how
70.17 to obtain an application for the Minnesota health care programs.
70.18 (b) For each child who is determined to be eligible for the free and reduced-price
70.19 school lunch program, the district shall provide the child's family with information on how
70.20 to obtain an application for the Minnesota health care programs and application assistance.
70.21 (c) A school district or charter school shall also ensure that applications and
70.22 information on application assistance are available at early childhood education sites and
70.23 public schools located within the district's jurisdiction.
70.24 (d) (c) Each district shall designate an enrollment specialist to provide application
70.25 assistance and follow-up services with families who have indicated an interest in receiving
70.26 information or an application for the Minnesota health care program. A district is eligible
70.27 for the application assistance bonus described in subdivision 5.
70.28 (e) Each (d) If a school district or charter school maintains a district Web site, the
70.29 school district or charter school shall provide on their its Web site a link to information on
70.30 how to obtain an application and application assistance.

70.31 Sec. 7. Minnesota Statutes 2008, section 256.963, is amended by adding a subdivision
70.32 to read:
70.33 Subd. 3. **Urgent dental care services.** The commissioner of human services shall
70.34 authorize pilot projects to reduce the total costs to the state for dental services provided

71.1 to persons enrolled in Minnesota health care programs by reducing hospital emergency
71.2 room costs for preventable and nonemergency dental services. The commissioner may
71.3 provide start-up funding and establish special payment rates for urgent dental care services
71.4 provided as an alternative to emergency room services and may change or waive existing
71.5 payment policies in order to adequately reimburse providers for providing cost-effective
71.6 alternative services in outpatient or urgent care settings. The commissioner may establish
71.7 a project in conjunction with the initiative authorized under subdivisions 1 and 2, or
71.8 establish new initiatives, or may implement both approaches.

71.9 Sec. 8. Minnesota Statutes 2008, section 256.969, subdivision 3a, is amended to read:
71.10 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical
71.11 assistance program must not be submitted until the recipient is discharged. However,
71.12 the commissioner shall establish monthly interim payments for inpatient hospitals that
71.13 have individual patient lengths of stay over 30 days regardless of diagnostic category.
71.14 Except as provided in section 256.9693, medical assistance reimbursement for treatment
71.15 of mental illness shall be reimbursed based on diagnostic classifications. Individual
71.16 hospital payments established under this section and sections 256.9685, 256.9686, and
71.17 256.9695, in addition to third party and recipient liability, for discharges occurring during
71.18 the rate year shall not exceed, in aggregate, the charges for the medical assistance covered
71.19 inpatient services paid for the same period of time to the hospital. This payment limitation
71.20 shall be calculated separately for medical assistance and general assistance medical
71.21 care services. The limitation on general assistance medical care shall be effective for
71.22 admissions occurring on or after July 1, 1991. Services that have rates established under
71.23 subdivision 11 or 12, must be limited separately from other services. After consulting with
71.24 the affected hospitals, the commissioner may consider related hospitals one entity and
71.25 may merge the payment rates while maintaining separate provider numbers. The operating
71.26 and property base rates per admission or per day shall be derived from the best Medicare
71.27 and claims data available when rates are established. The commissioner shall determine
71.28 the best Medicare and claims data, taking into consideration variables of recency of the
71.29 data, audit disposition, settlement status, and the ability to set rates in a timely manner.
71.30 The commissioner shall notify hospitals of payment rates by December 1 of the year
71.31 preceding the rate year. The rate setting data must reflect the admissions data used to
71.32 establish relative values. Base year changes from 1981 to the base year established for the
71.33 rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited
71.34 to the limits ending June 30, 1987, on the maximum rate of increase under subdivision
71.35 1. The commissioner may adjust base year cost, relative value, and case mix index data

72.1 to exclude the costs of services that have been discontinued by the October 1 of the year
72.2 preceding the rate year or that are paid separately from inpatient services. Inpatient stays
72.3 that encompass portions of two or more rate years shall have payments established based
72.4 on payment rates in effect at the time of admission unless the date of admission preceded
72.5 the rate year in effect by six months or more. In this case, operating payment rates for
72.6 services rendered during the rate year in effect and established based on the date of
72.7 admission shall be adjusted to the rate year in effect by the hospital cost index.

72.8 (b) For fee-for-service admissions occurring on or after July 1, 2002, the total
72.9 payment, before third-party liability and spenddown, made to hospitals for inpatient
72.10 services is reduced by .5 percent from the current statutory rates.

72.11 (c) In addition to the reduction in paragraph (b), the total payment for fee-for-service
72.12 admissions occurring on or after July 1, 2003, made to hospitals for inpatient services
72.13 before third-party liability and spenddown, is reduced five percent from the current
72.14 statutory rates. Mental health services within diagnosis related groups 424 to 432, and
72.15 facilities defined under subdivision 16 are excluded from this paragraph.

72.16 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for
72.17 fee-for-service admissions occurring on or after July 1, 2005, made to hospitals for
72.18 inpatient services before third-party liability and spenddown, is reduced 6.0 percent
72.19 from the current statutory rates. Mental health services within diagnosis related groups
72.20 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
72.21 Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical
72.22 assistance does not include general assistance medical care. Payments made to managed
72.23 care plans shall be reduced for services provided on or after January 1, 2006, to reflect
72.24 this reduction.

72.25 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
72.26 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made
72.27 to hospitals for inpatient services before third-party liability and spenddown, is reduced
72.28 3.46 percent from the current statutory rates. Mental health services with diagnosis related
72.29 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this
72.30 paragraph. Payments made to managed care plans shall be reduced for services provided
72.31 on or after January 1, 2009, through June 30, 2009, to reflect this reduction.

72.32 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
72.33 fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2010, made
72.34 to hospitals for inpatient services before third-party liability and spenddown, is reduced
72.35 1.9 percent from the current statutory rates. Mental health services with diagnosis related
72.36 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this

73.1 paragraph. Payments made to managed care plans shall be reduced for services provided
73.2 on or after July 1, 2009, through June 30, 2010, to reflect this reduction.

73.3 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment
73.4 for fee-for-service admissions occurring on or after July 1, 2010, made to hospitals for
73.5 inpatient services before third-party liability and spenddown, is reduced 1.79 percent
73.6 from the current statutory rates. Mental health services with diagnosis related groups
73.7 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
73.8 Payments made to managed care plans shall be reduced for services provided on or after
73.9 July 1, 2010, to reflect this reduction.

73.10 (h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total
73.11 payment for fee-for-service admissions occurring on or after July 1, 2009, made to
73.12 hospitals for inpatient services before third-party liability and spenddown, is reduced
73.13 3.0 percent from the current statutory rates. Facilities defined under subdivision 16 are
73.14 excluded from this paragraph. Payments made to managed care plans shall be reduced for
73.15 services provided on or after January 1, 2010, to reflect this reduction.

73.16 (i) In addition to the reductions in paragraphs (b) and (h), the total payment for
73.17 fee-for-service admissions occurring on or after July 1, 2009, made to hospitals for mental
73.18 health services within diagnosis-related groups 424 to 432 before third-party liability and
73.19 spenddown, is reduced 5.2 percent from the current statutory rates. Facilities defined under
73.20 subdivision 16 are excluded from this paragraph. Payments made to managed care plans
73.21 shall be reduced for services provided on or after January 1, 2010, to reflect this reduction.

73.22 Sec. 9. Minnesota Statutes 2008, section 256B.056, subdivision 3, is amended to read:

73.23 Subd. 3. **Asset limitations for individuals and families.** To be eligible for medical
73.24 assistance, a person must not individually own more than $3,000 in assets, or if a member
73.25 of a household with two family members, husband and wife, or parent and child, the
73.26 household must not own more than $6,000 in assets, plus $200 for each additional legal
73.27 dependent. In addition to these maximum amounts, an eligible individual or family may
73.28 accrue interest on these amounts, but they must be reduced to the maximum at the time
73.29 of an eligibility redetermination. The accumulation of the clothing and personal needs
73.30 allowance according to section 256B.35 must also be reduced to the maximum at the
73.31 time of the eligibility redetermination. The value of assets that are not considered in
73.32 determining eligibility for medical assistance is the value of those assets excluded under
73.33 the supplemental security income program for aged, blind, and disabled persons, with
73.34 the following exceptions:

73.35 (1) household goods and personal effects are not considered;

74.1 (2) capital and operating assets of a trade or business that the local agency
74.2 determines are necessary to the person's ability to earn an income are not considered. A
74.3 bank account that contains personal income or assets, or is used to pay personal expenses,
74.4 is not considered a capital or operating asset of a trade or business;
74.5 (3) motor vehicles are excluded to the same extent excluded by the supplemental
74.6 security income program;
74.7 (4) assets designated as burial expenses are excluded to the same extent excluded by
74.8 the supplemental security income program. Burial expenses funded by annuity contracts
74.9 or life insurance policies must irrevocably designate the individual's estate as contingent
74.10 beneficiary to the extent proceeds are not used for payment of selected burial expenses; and
74.11 (5) effective upon federal approval, for a person who no longer qualifies as an
74.12 employed person with a disability due to loss of earnings, assets allowed while eligible
74.13 for medical assistance under section 256B.057, subdivision 9, are not considered for 12
74.14 months, beginning with the first month of ineligibility as an employed person with a
74.15 disability, to the extent that the person's total assets remain within the allowed limits of
74.16 section 256B.057, subdivision 9, paragraph (c).

74.17 The assets specified in clause (2) must be disclosed to the local agency at the time of
74.18 application and at the time of an eligibility redetermination, and must be verified upon
74.19 request of the local agency.

74.20 **EFFECTIVE DATE.** This section is effective January 1, 2011, or upon federal
74.21 approval, whichever is later.

74.22 Sec. 10. Minnesota Statutes 2008, section 256B.056, subdivision 3b, is amended to
74.23 read:

74.24 Subd. 3b. **Treatment of trusts.** (a) A "medical assistance qualifying trust" is a
74.25 revocable or irrevocable trust, or similar legal device, established on or before August
74.26 10, 1993, by a person or the person's spouse under the terms of which the person
74.27 receives or could receive payments from the trust principal or income and the trustee
74.28 has discretion in making payments to the person from the trust principal or income.
74.29 Notwithstanding that definition, a medical assistance qualifying trust does not include:
74.30 (1) a trust set up by will; (2) a trust set up before April 7, 1986, solely to benefit a person
74.31 with a developmental disability living in an intermediate care facility for persons with
74.32 developmental disabilities; or (3) a trust set up by a person with payments made by the
74.33 Social Security Administration pursuant to the United States Supreme Court decision in
74.34 Sullivan v. Zebley, 110 S. Ct. 885 (1990). The maximum amount of payments that a

75.1 trustee of a medical assistance qualifying trust may make to a person under the terms of
75.2 the trust is considered to be available assets to the person, without regard to whether the
75.3 trustee actually makes the maximum payments to the person and without regard to the
75.4 purpose for which the medical assistance qualifying trust was established.

75.5 (b) Except as provided in paragraphs (c) and (d), trusts established after August 10,
75.6 1993, are treated according to section 13611(b) of the Omnibus Budget Reconciliation
75.7 Act of 1993 (OBRA), Public Law 103-66.

75.8 (c) For purposes of paragraph (d), a pooled trust means a trust established under
75.9 United States Code, title 42, section 1396p(d)(4)(C).

75.10 (d) A beneficiary's interest in a pooled trust is considered an available asset unless
75.11 the trust provides that upon the death of the beneficiary or termination of the trust during
75.12 the beneficiary's lifetime, whichever is sooner, the department receives any amount, up
75.13 to the amount of medical assistance benefits paid on behalf of the beneficiary, remaining
75.14 in the beneficiary's trust account after a deduction for reasonable administrative fees
75.15 and expenses, and an additional remainder amount. The retained remainder amount
75.16 of the subaccount must not exceed ten percent of the account value at the time of the
75.17 beneficiary's death or termination of the trust, and must only be used for the benefit of
75.18 disabled individuals who have a beneficiary interest in the pooled trust.

75.19 **EFFECTIVE DATE.** This section is effective for pooled trust accounts established
75.20 on or after January 1, 2011.

75.21 Sec. 11. Minnesota Statutes 2008, section 256B.056, subdivision 3c, is amended to
75.22 read:

75.23 Subd. 3c. **Asset limitations for families and children.** A household of two or more
75.24 persons must not own more than $20,000 in total net assets, and a household of one
75.25 person must not own more than $10,000 in total net assets. In addition to these maximum
75.26 amounts, an eligible individual or family may accrue interest on these amounts, but they
75.27 must be reduced to the maximum at the time of an eligibility redetermination. The value of
75.28 assets that are not considered in determining eligibility for medical assistance for families
75.29 and children is the value of those assets excluded under the AFDC state plan as of July 16,
75.30 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation
75.31 Act of 1996 (PRWORA), Public Law 104-193, with the following exceptions:

75.32 (1) household goods and personal effects are not considered;

75.33 (2) capital and operating assets of a trade or business up to $200,000 are not
75.34 considered, except that a bank account that contains personal income or assets, or is used to
75.35 pay personal expenses, is not considered a capital or operating asset of a trade or business;

76.1 (3) one motor vehicle is excluded for each person of legal driving age who is
76.2 employed or seeking employment;
76.3 (4) one burial plot and all other burial expenses equal to the supplemental security
76.4 income program asset limit are not considered for each individual;
76.5 (5) court-ordered settlements up to $10,000 are not considered;
76.6 (6) individual retirement accounts and funds are not considered; and
76.7 (7) assets owned by children are not considered.

76.8 The assets specified in clause (2) must be disclosed to the local agency at the time of
76.9 application and at the time of an eligibility redetermination, and must be verified upon
76.10 request of the local agency.

76.11 **EFFECTIVE DATE.** This section is effective January 1, 2011, or upon federal
76.12 approval, whichever is later.

76.13 Sec. 12. Minnesota Statutes 2008, section 256B.056, is amended by adding a
76.14 subdivision to read:
76.15 Subd. 10a. **Presumptive eligibility.** Medical assistance is available during a
76.16 presumptive period of eligibility that meets the requirements of United States Code,
76.17 title 42, section 1396r-1a. Presumptive eligibility shall be determined by the state or
76.18 local agency for children under age 19 who appear to meet income requirements of
76.19 section 256B.057, subdivisions 1, 2, and 8, on the basis of preliminary information. The
76.20 presumptive period begins on the first day of the month in which presumptive eligibility is
76.21 determined. The agency must provide notice of presumptive eligibility and information
76.22 on the procedures for completing the eligibility process. The presumptive period ends
76.23 on the earlier of the date of the determination for medical assistance eligibility, or the
76.24 last day of the month following the presumptive eligibility determination if a complete
76.25 application with requested verifications is not submitted by that date. Enrollees who are
76.26 terminated for failure to complete an application or provide verifications cannot be granted
76.27 presumptive eligibility again for 12 months.

76.28 **EFFECTIVE DATE.** This section is effective July 1, 2011, or upon federal
76.29 approval, whichever is later.

76.30 Sec. 13. Minnesota Statutes 2008, section 256B.057, subdivision 3, is amended to read:
76.31 Subd. 3. **Qualified Medicare beneficiaries.** A person who is entitled to Part A
76.32 Medicare benefits, whose income is equal to or less than 100 percent of the federal
76.33 poverty guidelines, and whose assets are no more than ~~$10,000 for a single individual~~

77.1 ~~and $18,000 for a married couple or family of two or more~~ the maximum resource
77.2 level applied for the year for an individual or an individual and the individual's spouse
77.3 according to United States Code, title 42, section 1396d(p)(1)(C), is eligible for medical
77.4 assistance reimbursement of Part A and Part B premiums, Part A and Part B coinsurance
77.5 and deductibles, and cost-effective premiums for enrollment with a health maintenance
77.6 organization or a competitive medical plan under section 1876 of the Social Security Act.
77.7 Reimbursement of the Medicare coinsurance and deductibles, when added to the amount
77.8 paid by Medicare, must not exceed the total rate the provider would have received for the
77.9 same service or services if the person were a medical assistance recipient with Medicare
77.10 coverage. Increases in benefits under Title II of the Social Security Act shall not be
77.11 counted as income for purposes of this subdivision until July 1 of each year.

77.12 **EFFECTIVE DATE.** This section is effective January 1, 2012.

77.13 Sec. 14. Minnesota Statutes 2008, section 256B.057, subdivision 9, is amended to read:
77.14 Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid
77.15 for a person who is employed and who:
77.16 (1) meets the definition of disabled under the supplemental security income program;
77.17 (2) is at least 16 but less than 65 years of age;
77.18 (3) meets the asset limits in paragraph (c); and
77.19 (4) effective November 1, 2003, pays a premium and other obligations under
77.20 paragraph (e).

77.21 Any spousal income or assets shall be disregarded for purposes of eligibility and premium
77.22 determinations.
77.23 (b) After the month of enrollment, a person enrolled in medical assistance under
77.24 this subdivision who:
77.25 (1) is temporarily unable to work and without receipt of earned income due to a
77.26 medical condition, as verified by a physician, may retain eligibility for up to four calendar
77.27 months; or
77.28 (2) effective January 1, 2004, loses employment for reasons not attributable to the
77.29 enrollee, may retain eligibility for up to four consecutive months after the month of job
77.30 loss. To receive a four-month extension, enrollees must verify the medical condition or
77.31 provide notification of job loss. All other eligibility requirements must be met and the
77.32 enrollee must pay all calculated premium costs for continued eligibility.
77.33 (c) For purposes of determining eligibility under this subdivision, a person's assets
77.34 must not exceed $20,000, excluding:

78.1 (1) all assets excluded under section 256B.056;
78.2 (2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans,
78.3 Keogh plans, and pension plans; and
78.4 (3) medical expense accounts set up through the person's employer.
78.5 (d)(1) Effective January 1, 2004, for purposes of eligibility, there will be a $65
78.6 earned income disregard. To be eligible, a person applying for medical assistance under
78.7 this subdivision must have earned income above the disregard level.
78.8 (2) Effective January 1, 2004, to be considered earned income, Medicare, Social
78.9 Security, and applicable state and federal income taxes must be withheld. To be eligible,
78.10 a person must document earned income tax withholding.
78.11 (e)(1) A person whose earned and unearned income is equal to or greater than 100
78.12 percent of federal poverty guidelines for the applicable family size must pay a premium
78.13 to be eligible for medical assistance under this subdivision. The premium shall be based
78.14 on the person's gross earned and unearned income and the applicable family size using a
78.15 sliding fee scale established by the commissioner, which begins at one percent of income
78.16 at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income
78.17 for those with incomes at or above 300 percent of the federal poverty guidelines. Annual
78.18 adjustments in the premium schedule based upon changes in the federal poverty guidelines
78.19 shall be effective for premiums due in July of each year.
78.20 (2) Effective January 1, 2004, all enrollees must pay a premium to be eligible for
78.21 medical assistance under this subdivision. An enrollee shall pay the greater of a ~~$35~~ <u>$50</u>
78.22 premium or the premium calculated in clause (1).
78.23 (3) Effective November 1, 2003, all enrollees who receive unearned income must
78.24 pay ~~one-half of one~~ <u>2.5</u> percent of unearned income in addition to the premium amount.
78.25 (4) Effective November 1, 2003, for enrollees whose income does not exceed 200
78.26 percent of the federal poverty guidelines and who are also enrolled in Medicare, the
78.27 commissioner must reimburse the enrollee for Medicare Part B premiums under section
78.28 256B.0625, subdivision 15, paragraph (a).
78.29 (5) Increases in benefits under title II of the Social Security Act shall not be counted
78.30 as income for purposes of this subdivision until July 1 of each year.
78.31 (f) A person's eligibility and premium shall be determined by the local county
78.32 agency. Premiums must be paid to the commissioner. All premiums are dedicated to
78.33 the commissioner.
78.34 (g) Any required premium shall be determined at application and redetermined at
78.35 the enrollee's six-month income review or when a change in income or household size is
78.36 reported. Enrollees must report any change in income or household size within ten days

79.1 of when the change occurs. A decreased premium resulting from a reported change in
79.2 income or household size shall be effective the first day of the next available billing month
79.3 after the change is reported. Except for changes occurring from annual cost-of-living
79.4 increases, a change resulting in an increased premium shall not affect the premium amount
79.5 until the next six-month review.

79.6 (h) Premium payment is due upon notification from the commissioner of the
79.7 premium amount required. Premiums may be paid in installments at the discretion of
79.8 the commissioner.

79.9 (i) Nonpayment of the premium shall result in denial or termination of medical
79.10 assistance unless the person demonstrates good cause for nonpayment. Good cause exists
79.11 if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to
79.12 D, are met. Except when an installment agreement is accepted by the commissioner,
79.13 all persons disenrolled for nonpayment of a premium must pay any past due premiums
79.14 as well as current premiums due prior to being reenrolled. Nonpayment shall include
79.15 payment with a returned, refused, or dishonored instrument. The commissioner may
79.16 require a guaranteed form of payment as the only means to replace a returned, refused,
79.17 or dishonored instrument.

79.18 **EFFECTIVE DATE.** This section is effective January 1, 2011.

79.19 Sec. 15. Minnesota Statutes 2008, section 256B.057, is amended by adding a
79.20 subdivision to read:

79.21 Subd. 11. **Treatment for colorectal cancer.** (a) State-only funded medical
79.22 assistance may be paid for an individual who:

79.23 (1) has been screened for colorectal cancer by the colorectal cancer prevention
79.24 demonstration project;

79.25 (2) according to the individual's treating health professional, needs treatment for
79.26 colorectal cancer;

79.27 (3) meets income eligibility guidelines for the colorectal cancer prevention
79.28 demonstration project;

79.29 (4) is under the age of 65; and

79.30 (5) is not otherwise eligible for federally funded medical assistance or covered under
79.31 creditable coverage as defined under United States Code, title 42, section 1396a(aa).

79.32 (b) Medical assistance provided under this subdivision shall be limited to services
79.33 provided during the period that the individual receives treatment for colorectal cancer.

80.1 (c) An individual meeting the criteria in paragraph (a) is eligible for state-only
80.2 funded medical assistance without meeting the eligibility criteria relating to income and
80.3 assets in section 256B.056, subdivisions 1a to 5b.

80.4 Sec. 16. Minnesota Statutes 2008, section 256B.0575, is amended to read:

80.5 **256B.0575 AVAILABILITY OF INCOME FOR INSTITUTIONALIZED**
80.6 **PERSONS.**

80.7 Subdivision 1. **Income deductions.** When an institutionalized person is determined
80.8 eligible for medical assistance, the income that exceeds the deductions in paragraphs (a)
80.9 and (b) must be applied to the cost of institutional care.

80.10 (a) The following amounts must be deducted from the institutionalized person's
80.11 income in the following order:

80.12 (1) the personal needs allowance under section 256B.35 or, for a veteran who
80.13 does not have a spouse or child, or a surviving spouse of a veteran having no child, the
80.14 amount of an improved pension received from the veteran's administration not exceeding
80.15 $90 per month;

80.16 (2) the personal allowance for disabled individuals under section 256B.36;

80.17 (3) if the institutionalized person has a legally appointed guardian or conservator,
80.18 five percent of the recipient's gross monthly income up to $100 as reimbursement for
80.19 guardianship or conservatorship services;

80.20 (4) a monthly income allowance determined under section 256B.058, subdivision
80.21 2, but only to the extent income of the institutionalized spouse is made available to the
80.22 community spouse;

80.23 (5) a monthly allowance for children under age 18 which, together with the net
80.24 income of the children, would provide income equal to the medical assistance standard
80.25 for families and children according to section 256B.056, subdivision 4, for a family size
80.26 that includes only the minor children. This deduction applies only if the children do not
80.27 live with the community spouse and only to the extent that the deduction is not included
80.28 in the personal needs allowance under section 256B.35, subdivision 1, as child support
80.29 garnished under a court order;

80.30 (6) a monthly family allowance for other family members, equal to one-third of the
80.31 difference between 122 percent of the federal poverty guidelines and the monthly income
80.32 for that family member;

80.33 (7) reparations payments made by the Federal Republic of Germany and reparations
80.34 payments made by the Netherlands for victims of Nazi persecution between 1940 and
80.35 1945;

(8) all other exclusions from income for institutionalized persons as mandated by federal law; and

(9) amounts for reasonable expenses, as specified in subdivision 2, incurred for necessary medical or remedial care for the institutionalized person that are recognized under state law, not medical assistance covered expenses, and ~~that are~~ not subject to payment by a third party.

~~Reasonable expenses are limited to expenses that have not been previously used as a deduction from income and are incurred during the enrollee's current period of eligibility, including retroactive months associated with the current period of eligibility, for medical assistance payment of long-term care services.~~

For purposes of clause (6), "other family member" means a person who resides with the community spouse and who is a minor or dependent child, dependent parent, or dependent sibling of either spouse. "Dependent" means a person who could be claimed as a dependent for federal income tax purposes under the Internal Revenue Code.

(b) Income shall be allocated to an institutionalized person for a period of up to three calendar months, in an amount equal to the medical assistance standard for a family size of one if:

(1) a physician certifies that the person is expected to reside in the long-term care facility for three calendar months or less;

(2) if the person has expenses of maintaining a residence in the community; and

(3) if one of the following circumstances apply:

(i) the person was not living together with a spouse or a family member as defined in paragraph (a) when the person entered a long-term care facility; or

(ii) the person and the person's spouse become institutionalized on the same date, in which case the allocation shall be applied to the income of one of the spouses.

For purposes of this paragraph, a person is determined to be residing in a licensed nursing home, regional treatment center, or medical institution if the person is expected to remain for a period of one full calendar month or more.

Subd. 2. **Reasonable expenses.** (a) For the purposes of subdivision 1, paragraph (a), clause (9), reasonable expenses are limited to expenses that have not been previously used as a deduction from income and were not:

(1) for long-term care expenses incurred during a period of ineligibility as defined in section 256B.0595, subdivision 2;

(2) incurred more than three months before the month of application associated with the current period of eligibility;

82.1 (3) for expenses incurred by a recipient that are duplicative of services that are
82.2 covered under chapter 256B; or
82.3 (4) nursing facility expenses incurred without a timely assessment as required under
82.4 section 256B.0911.

82.5 Sec. 17. Minnesota Statutes 2008, section 256B.0595, subdivision 1, is amended to
82.6 read:
82.7 Subdivision 1. **Prohibited transfers.** (a) For transfers of assets made on or before
82.8 August 10, 1993, if an institutionalized person or the institutionalized person's spouse has
82.9 given away, sold, or disposed of, for less than fair market value, any asset or interest
82.10 therein, except assets other than the homestead that are excluded under the supplemental
82.11 security program, within 30 months before or any time after the date of institutionalization
82.12 if the person has been determined eligible for medical assistance, or within 30 months
82.13 before or any time after the date of the first approved application for medical assistance
82.14 if the person has not yet been determined eligible for medical assistance, the person is
82.15 ineligible for long-term care services for the period of time determined under subdivision
82.16 2.
82.17 (b) Effective for transfers made after August 10, 1993, an institutionalized person, an
82.18 institutionalized person's spouse, or any person, court, or administrative body with legal
82.19 authority to act in place of, on behalf of, at the direction of, or upon the request of the
82.20 institutionalized person or institutionalized person's spouse, may not give away, sell, or
82.21 dispose of, for less than fair market value, any asset or interest therein, except assets other
82.22 than the homestead that are excluded under the Supplemental Security Income program,
82.23 for the purpose of establishing or maintaining medical assistance eligibility. This applies
82.24 to all transfers, including those made by a community spouse after the month in which
82.25 the institutionalized spouse is determined eligible for medical assistance. For purposes of
82.26 determining eligibility for long-term care services, any transfer of such assets within 36
82.27 months before or any time after an institutionalized person requests medical assistance
82.28 payment of long-term care services, or 36 months before or any time after a medical
82.29 assistance recipient becomes an institutionalized person, for less than fair market value
82.30 may be considered. Any such transfer is presumed to have been made for the purpose
82.31 of establishing or maintaining medical assistance eligibility and the institutionalized
82.32 person is ineligible for long-term care services for the period of time determined under
82.33 subdivision 2, unless the institutionalized person furnishes convincing evidence to
82.34 establish that the transaction was exclusively for another purpose, or unless the transfer is
82.35 permitted under subdivision 3 or 4. In the case of payments from a trust or portions of a

83.1 trust that are considered transfers of assets under federal law, or in the case of any other
83.2 disposal of assets made on or after February 8, 2006, any transfers made within 60 months
83.3 before or any time after an institutionalized person requests medical assistance payment of
83.4 long-term care services and within 60 months before or any time after a medical assistance
83.5 recipient becomes an institutionalized person, may be considered.

83.6 (c) This section applies to transfers, for less than fair market value, of income
83.7 or assets, including assets that are considered income in the month received, such as
83.8 inheritances, court settlements, and retroactive benefit payments or income to which the
83.9 institutionalized person or the institutionalized person's spouse is entitled but does not
83.10 receive due to action by the institutionalized person, the institutionalized person's spouse,
83.11 or any person, court, or administrative body with legal authority to act in place of, on
83.12 behalf of, at the direction of, or upon the request of the institutionalized person or the
83.13 institutionalized person's spouse.

83.14 (d) This section applies to payments for care or personal services provided by a
83.15 relative, unless the compensation was stipulated in a notarized, written agreement which
83.16 was in existence when the service was performed, the care or services directly benefited
83.17 the person, and the payments made represented reasonable compensation for the care
83.18 or services provided. A notarized written agreement is not required if payment for the
83.19 services was made within 60 days after the service was provided.

83.20 (e) This section applies to the portion of any asset or interest that an institutionalized
83.21 person, an institutionalized person's spouse, or any person, court, or administrative body
83.22 with legal authority to act in place of, on behalf of, at the direction of, or upon the request
83.23 of the institutionalized person or the institutionalized person's spouse, transfers to any
83.24 annuity that exceeds the value of the benefit likely to be returned to the institutionalized
83.25 person or institutionalized person's spouse while alive, based on estimated life expectancy
83.26 as determined according to the current actuarial tables published by the Office of the
83.27 Chief Actuary of the Social Security Administration. The commissioner may adopt rules
83.28 reducing life expectancies based on the need for long-term care. This section applies to an
83.29 annuity purchased on or after March 1, 2002, that:

83.30 (1) is not purchased from an insurance company or financial institution that is
83.31 subject to licensing or regulation by the Minnesota Department of Commerce or a similar
83.32 regulatory agency of another state;

83.33 (2) does not pay out principal and interest in equal monthly installments; or

83.34 (3) does not begin payment at the earliest possible date after annuitization.

83.35 (f) Effective for transactions, including the purchase of an annuity, occurring on or
83.36 after February 8, 2006, by or on behalf of an institutionalized person who has applied for

84.1 or is receiving long-term care services or the institutionalized person's spouse shall be
84.2 treated as the disposal of an asset for less than fair market value unless the department is
84.3 named a preferred remainder beneficiary as described in section 256B.056, subdivision
84.4 11. Any subsequent change to the designation of the department as a preferred remainder
84.5 beneficiary shall result in the annuity being treated as a disposal of assets for less than
84.6 fair market value. The amount of such transfer shall be the maximum amount the
84.7 institutionalized person or the institutionalized person's spouse could receive from the
84.8 annuity or similar financial instrument. Any change in the amount of the income or
84.9 principal being withdrawn from the annuity or other similar financial instrument at the
84.10 time of the most recent disclosure shall be deemed to be a transfer of assets for less than
84.11 fair market value unless the institutionalized person or the institutionalized person's spouse
84.12 demonstrates that the transaction was for fair market value. In the event a distribution
84.13 of income or principal has been improperly distributed or disbursed from an annuity or
84.14 other retirement planning instrument of an institutionalized person or the institutionalized
84.15 person's spouse, a cause of action exists against the individual receiving the improper
84.16 distribution for the cost of medical assistance services provided or the amount of the
84.17 improper distribution, whichever is less.

84.18 (g) Effective for transactions, including the purchase of an annuity, occurring on
84.19 or after February 8, 2006, by or on behalf of an institutionalized person applying for or
84.20 receiving long-term care services shall be treated as a disposal of assets for less than fair
84.21 market value unless it is:

84.22 (i) an annuity described in subsection (b) or (q) of section 408 of the Internal
84.23 Revenue Code of 1986; or

84.24 (ii) purchased with proceeds from:

84.25 (A) an account or trust described in subsection (a), (c), or (p) of section 408 of the
84.26 Internal Revenue Code;

84.27 (B) a simplified employee pension within the meaning of section 408(k) of the
84.28 Internal Revenue Code; or

84.29 (C) a Roth IRA described in section 408A of the Internal Revenue Code; or

84.30 (iii) an annuity that is irrevocable and nonassignable; is actuarially sound as
84.31 determined in accordance with actuarial publications of the Office of the Chief Actuary of
84.32 the Social Security Administration; and provides for payments in equal amounts during
84.33 the term of the annuity, with no deferral and no balloon payments made.

84.34 (h) For purposes of this section, long-term care services include services in a nursing
84.35 facility, services that are eligible for payment according to section 256B.0625, subdivision
84.36 2, because they are provided in a swing bed, intermediate care facility for persons with

85.1 developmental disabilities, and home and community-based services provided pursuant
85.2 to sections 256B.0915, 256B.092, and 256B.49. For purposes of this subdivision and
85.3 subdivisions 2, 3, and 4, "institutionalized person" includes a person who is an inpatient
85.4 in a nursing facility or in a swing bed, or intermediate care facility for persons with
85.5 developmental disabilities or who is receiving home and community-based services under
85.6 sections 256B.0915, 256B.092, and 256B.49.

85.7 (i) This section applies to funds used to purchase a promissory note, loan, or
85.8 mortgage unless the note, loan, or mortgage:

85.9 (1) has a repayment term that is actuarially sound;

85.10 (2) provides for payments to be made in equal amounts during the term of the loan,
85.11 with no deferral and no balloon payments made; and

85.12 (3) prohibits the cancellation of the balance upon the death of the lender.

85.13 In the case of a promissory note, loan, or mortgage that does not meet an exception
85.14 in clauses (1) to (3), the value of such note, loan, or mortgage shall be the outstanding
85.15 balance due as of the date of the institutionalized person's request for medical assistance
85.16 payment of long-term care services.

85.17 (j) This section applies to the purchase of a life estate interest in another person's
85.18 home unless the purchaser resides in the home for a period of at least one year after the
85.19 date of purchase.

85.20 (k) This section applies to transfers into a pooled trust that qualifies under United
85.21 States Code, title 42, section 1396p(d)(4)(C), by:

85.22 (1) a person age 65 or older or the person's spouse; or

85.23 (2) any person, court, or administrative body with legal authority to act in place
85.24 of, on behalf of, at the direction of, or upon the request of a person age 65 or older or
85.25 the person's spouse.

85.26 Sec. 18. Minnesota Statutes 2008, section 256B.0595, subdivision 2, is amended to
85.27 read:

85.28 Subd. 2. **Period of ineligibility for long-term care services.** (a) For any
85.29 uncompensated transfer occurring on or before August 10, 1993, the number of months
85.30 of ineligibility for long-term care services shall be the lesser of 30 months, or the
85.31 uncompensated transfer amount divided by the average medical assistance rate for nursing
85.32 facility services in the state in effect on the date of application. The amount used to
85.33 calculate the average medical assistance payment rate shall be adjusted each July 1 to
85.34 reflect payment rates for the previous calendar year. The period of ineligibility begins
85.35 with the month in which the assets were transferred. If the transfer was not reported to

86.1 the local agency at the time of application, and the applicant received long-term care
86.2 services during what would have been the period of ineligibility if the transfer had been
86.3 reported, a cause of action exists against the transferee for the cost of long-term care
86.4 services provided during the period of ineligibility, or for the uncompensated amount of
86.5 the transfer, whichever is less. The uncompensated transfer amount is the fair market
86.6 value of the asset at the time it was given away, sold, or disposed of, less the amount of
86.7 compensation received.

86.8 (b) For uncompensated transfers made after August 10, 1993, the number of months
86.9 of ineligibility for long-term care services shall be the total uncompensated value of the
86.10 resources transferred divided by the average medical assistance rate for nursing facility
86.11 services in the state in effect on the date of application. The amount used to calculate
86.12 the average medical assistance payment rate shall be adjusted each July 1 to reflect
86.13 payment rates for the previous calendar year. The period of ineligibility begins with the
86.14 first day of the month after the month in which the assets were transferred except that
86.15 if one or more uncompensated transfers are made during a period of ineligibility, the
86.16 total assets transferred during the ineligibility period shall be combined and a penalty
86.17 period calculated to begin on the first day of the month after the month in which the first
86.18 uncompensated transfer was made. If the transfer was reported to the local agency after
86.19 the date that advance notice of a period of ineligibility that affects the next month could
86.20 be provided to the recipient and the recipient received medical assistance services or the
86.21 transfer was not reported to the local agency, and the applicant or recipient received
86.22 medical assistance services during what would have been the period of ineligibility if
86.23 the transfer had been reported, a cause of action exists against the transferee for that
86.24 portion of long-term care services provided during the period of ineligibility, or for the
86.25 uncompensated amount of the transfer, whichever is less. The uncompensated transfer
86.26 amount is the fair market value of the asset at the time it was given away, sold, or disposed
86.27 of, less the amount of compensation received. Effective for transfers made on or after
86.28 March 1, 1996, involving persons who apply for medical assistance on or after April 13,
86.29 1996, no cause of action exists for a transfer unless:

86.30 (1) the transferee knew or should have known that the transfer was being made by a
86.31 person who was a resident of a long-term care facility or was receiving that level of care in
86.32 the community at the time of the transfer;

86.33 (2) the transferee knew or should have known that the transfer was being made to
86.34 assist the person to qualify for or retain medical assistance eligibility; or

86.35 (3) the transferee actively solicited the transfer with intent to assist the person to
86.36 qualify for or retain eligibility for medical assistance.

(c) For uncompensated transfers made on or after February 8, 2006, the period of ineligibility:

(1) for uncompensated transfers by or on behalf of individuals receiving medical assistance payment of long-term care services, begins the first day of the month following advance notice of the ~~penalty~~ period of ineligibility, but no later than the first day of the month that follows three full calendar months from the date of the report or discovery of the transfer; or

(2) for uncompensated transfers by individuals requesting medical assistance payment of long-term care services, begins the date on which the individual is eligible for medical assistance under the Medicaid state plan and would otherwise be receiving long-term care services based on an approved application for such care but for the ~~application of the penalty~~ period of ineligibility resulting from the uncompensated transfer; and

(3) cannot begin during any other period of ineligibility.

(d) If a calculation of a ~~penalty~~ period of ineligibility results in a partial month, payments for long-term care services shall be reduced in an amount equal to the fraction.

(e) In the case of multiple fractional transfers of assets in more than one month for less than fair market value on or after February 8, 2006, the period of ineligibility is calculated by treating the total, cumulative, uncompensated value of all assets transferred during all months on or after February 8, 2006, as one transfer.

(f) A period of ineligibility established under paragraph (c) may be eliminated if all of the assets transferred for less than fair market value used to calculate the period of ineligibility, or cash equal to the value of the assets at the time of the transfer, are returned within 12 months after the date the period of ineligibility began. A period of ineligibility must not be adjusted if less than the full amount of the transferred assets or the full cash value of the transferred assets are returned.

EFFECTIVE DATE. This section is effective for periods of ineligibility established on or after January 1, 2011.

Sec. 19. Minnesota Statutes 2008, section 256B.06, subdivision 4, is amended to read:

Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited to citizens of the United States, qualified noncitizens as defined in this subdivision, and other persons residing lawfully in the United States. Citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

88.1 (b) "Qualified noncitizen" means a person who meets one of the following
88.2 immigration criteria:
88.3 (1) admitted for lawful permanent residence according to United States Code, title 8;
88.4 (2) admitted to the United States as a refugee according to United States Code,
88.5 title 8, section 1157;
88.6 (3) granted asylum according to United States Code, title 8, section 1158;
88.7 (4) granted withholding of deportation according to United States Code, title 8,
88.8 section 1253(h);
88.9 (5) paroled for a period of at least one year according to United States Code, title 8,
88.10 section 1182(d)(5);
88.11 (6) granted conditional entrant status according to United States Code, title 8,
88.12 section 1153(a)(7);
88.13 (7) determined to be a battered noncitizen by the United States Attorney General
88.14 according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996,
88.15 title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;
88.16 (8) is a child of a noncitizen determined to be a battered noncitizen by the United
88.17 States Attorney General according to the Illegal Immigration Reform and Immigrant
88.18 Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill,
88.19 Public Law 104-200; or
88.20 (9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public
88.21 Law 96-422, the Refugee Education Assistance Act of 1980.
88.22 (c) All qualified noncitizens who were residing in the United States before August
88.23 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for
88.24 medical assistance with federal financial participation.
88.25 (d) All qualified noncitizens who entered the United States on or after August 22,
88.26 1996, and who otherwise meet the eligibility requirements of this chapter, are eligible for
88.27 medical assistance with federal financial participation through November 30, 1996.
88.28 Beginning December 1, 1996, qualified noncitizens who entered the United States
88.29 on or after August 22, 1996, and who otherwise meet the eligibility requirements of this
88.30 chapter are eligible for medical assistance with federal participation for five years if they
88.31 meet one of the following criteria:
88.32 (i) refugees admitted to the United States according to United States Code, title 8,
88.33 section 1157;
88.34 (ii) persons granted asylum according to United States Code, title 8, section 1158;
88.35 (iii) persons granted withholding of deportation according to United States Code,
88.36 title 8, section 1253(h);

89.1 (iv) veterans of the United States armed forces with an honorable discharge for
89.2 a reason other than noncitizen status, their spouses and unmarried minor dependent
89.3 children; or

89.4 (v) persons on active duty in the United States armed forces, other than for training,
89.5 their spouses and unmarried minor dependent children.

89.6 Beginning December 1, 1996, qualified noncitizens who do not meet one of the
89.7 criteria in items (i) to (v) are eligible for medical assistance without federal financial
89.8 participation as described in paragraph (j).

89.9 Notwithstanding paragraph (j), beginning July 1, 2010, children and pregnant
89.10 women who are qualified noncitizens, as described in paragraph (b), are eligible for
89.11 medical assistance with federal financial participation as provided by the federal Children's
89.12 Health Insurance Program Reauthorization Act of 2009, Public Law 111-3.

89.13 (e) Noncitizens who are not qualified noncitizens as defined in paragraph (b), who
89.14 are lawfully present in the United States, as defined in Code of Federal Regulations, title
89.15 8, section 103.12, and who otherwise meet the eligibility requirements of this chapter, are
89.16 eligible for medical assistance under clauses (1) to (3). These individuals must cooperate
89.17 with the United States Citizenship and Immigration Services to pursue any applicable
89.18 immigration status, including citizenship, that would qualify them for medical assistance
89.19 with federal financial participation.

89.20 (1) Persons who were medical assistance recipients on August 22, 1996, are eligible
89.21 for medical assistance with federal financial participation through December 31, 1996.

89.22 (2) Beginning January 1, 1997, persons described in clause (1) are eligible for
89.23 medical assistance without federal financial participation as described in paragraph (j).

89.24 (3) Beginning December 1, 1996, persons residing in the United States prior to
89.25 August 22, 1996, who were not receiving medical assistance and persons who arrived on
89.26 or after August 22, 1996, are eligible for medical assistance without federal financial
89.27 participation as described in paragraph (j).

89.28 (f) Nonimmigrants who otherwise meet the eligibility requirements of this chapter
89.29 are eligible for the benefits as provided in paragraphs (g) to (i). For purposes of this
89.30 subdivision, a "nonimmigrant" is a person in one of the classes listed in United States
89.31 Code, title 8, section 1101(a)(15).

89.32 (g) Payment shall also be made for care and services that are furnished to noncitizens,
89.33 regardless of immigration status, who otherwise meet the eligibility requirements of
89.34 this chapter, if such care and services are necessary for the treatment of an emergency
89.35 medical condition, except for organ transplants and related care and services and routine
89.36 prenatal care.

90.1 (h) For purposes of this subdivision, the term "emergency medical condition" means
90.2 a medical condition that meets the requirements of United States Code, title 42, section
90.3 1396b(v).

90.4 (i) Beginning July 1, 2009, pregnant noncitizens who are undocumented,
90.5 nonimmigrants, or ~~eligible for medical assistance as described in paragraph (j),~~ lawfully
90.6 present as designated in paragraph (e) and who are not covered by a group health plan
90.7 or health insurance coverage according to Code of Federal Regulations, title 42, section
90.8 457.310, and who otherwise meet the eligibility requirements of this chapter, are eligible
90.9 for medical assistance through the period of pregnancy, including labor and delivery,
90.10 and 60 days postpartum, to the extent federal funds are available under title XXI of the
90.11 Social Security Act, and the state children's health insurance program~~, followed by 60~~
90.12 ~~days postpartum without federal financial participation~~.

90.13 (j) Qualified noncitizens as described in paragraph (d), and all other noncitizens
90.14 lawfully residing in the United States as described in paragraph (e), who are ineligible
90.15 for medical assistance with federal financial participation and who otherwise meet the
90.16 eligibility requirements of chapter 256B and of this paragraph, are eligible for medical
90.17 assistance without federal financial participation. Qualified noncitizens as described
90.18 in paragraph (d) are only eligible for medical assistance without federal financial
90.19 participation for five years from their date of entry into the United States.

90.20 (k) Beginning October 1, 2003, persons who are receiving care and rehabilitation
90.21 services from a nonprofit center established to serve victims of torture and are otherwise
90.22 ineligible for medical assistance under this chapter are eligible for medical assistance
90.23 without federal financial participation. These individuals are eligible only for the period
90.24 during which they are receiving services from the center. Individuals eligible under this
90.25 paragraph shall not be required to participate in prepaid medical assistance.

90.26 **EFFECTIVE DATE.** This section is effective July 1, 2009.

90.27 Sec. 20. Minnesota Statutes 2008, section 256B.06, subdivision 5, is amended to read:

90.28 Subd. 5. **Deeming of sponsor income and resources.** When determining eligibility
90.29 for any federal or state funded medical assistance under this section, the income
90.30 and resources of all noncitizens shall be deemed to include their sponsors' income
90.31 and resources as required under the Personal Responsibility and Work Opportunity
90.32 Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and
90.33 subsequently set out in federal rules. This section is effective May 1, 1997. Beginning
90.34 July 1, 2010, sponsor deeming does not apply to pregnant women and children who are
90.35 qualified noncitizens, as described in section 256B.06, subdivision 4, paragraph (b).

91.1 **EFFECTIVE DATE.** This section is effective July 1, 2010.

91.2 Sec. 21. Minnesota Statutes 2008, section 256B.0625, subdivision 3c, is amended to
91.3 read:

91.4 Subd. 3c. **Health Services Policy Committee.** (a) The commissioner, after
91.5 receiving recommendations from professional physician associations, professional
91.6 associations representing licensed nonphysician health care professionals, and consumer
91.7 groups, shall establish a 13-member Health Services Policy Committee, which consists of
91.8 12 voting members and one nonvoting member. The Health Services Policy Committee
91.9 shall advise the commissioner regarding health services pertaining to the administration
91.10 of health care benefits covered under the medical assistance, general assistance medical
91.11 care, and MinnesotaCare programs. The Health Services Policy Committee shall meet at
91.12 least quarterly. The Health Services Policy Committee shall annually elect a physician
91.13 chair from among its members, who shall work directly with the commissioner's medical
91.14 director, to establish the agenda for each meeting. The Health Services Policy Committee
91.15 shall also recommend criteria for verifying centers of excellence for specific aspects of
91.16 medical care where a specific set of combined services, a volume of patients necessary to
91.17 maintain a high level of competency, or a specific level of technical capacity is associated
91.18 with improved health outcomes.

91.19 (b) The commissioner shall establish a dental subcommittee to operate under the
91.20 Health Services Policy Committee. The dental subcommittee consists of general dentists,
91.21 dental specialists, safety net providers, dental hygienists, health plan company and
91.22 county and public health representatives, health researchers, consumers, and a designee
91.23 of the commissioner of health. The dental subcommittee shall advise the commissioner
91.24 regarding:

91.25 (1) the critical access dental program under section 256B.76, subdivision 4;

91.26 (2) any changes to the critical access dental provider program necessary to comply
91.27 with program expenditure limits;

91.28 (3) dental coverage policy based on evidence, quality, continuity of care, and best
91.29 practices;

91.30 (4) the development of dental delivery models; and

91.31 (5) dental services to be added or eliminated from subdivision 9, paragraph (b).

91.32 (c) The Health Services Policy Committee shall study approaches to making
91.33 provider reimbursement under the medical assistance, MinnesotaCare, and general
91.34 assistance medical care programs contingent on patient participation in a patient-centered
91.35 decision-making process, and shall evaluate the impact of these approaches on health

care quality, patient satisfaction, and health care costs. The committee shall present findings and recommendations to the commissioner and the legislative committees with jurisdiction over health care by January 15, 2010.

(d) The Health Services Policy Committee shall monitor and track the practice patterns of physicians providing services to medical assistance, MinnesotaCare, and general assistance medical care enrollees under fee-for-service, managed care, and county-based purchasing. The committee shall focus on services or specialties for which there is a high variation in utilization across physicians, or which are associated with high medical costs. The commissioner, based upon the findings of the committee, shall regularly notify physicians whose practice patterns indicate higher than average utilization or costs. Managed care and county-based purchasing plans shall provide the committee with utilization and cost data necessary to implement this paragraph.

Sec. 22. Minnesota Statutes 2008, section 256B.0625, subdivision 9, is amended to read:

Subd. 9. **Dental services.** (a) Medical assistance covers dental services. ~~Dental services include, with prior authorization, fixed bridges that are cost-effective for persons who cannot use removable dentures because of their medical condition.~~

(b) Medical assistance dental coverage for nonpregnant adults is limited to the following services:

(1) comprehensive exams, limited to once every five years;

(2) periodic exams, limited to one per year;

(3) limited exams;

(4) bitewing x-rays, limited to one per year;

(5) periapical x-rays;

(6) panoramic x-rays, limited to one every five years, and only if provided in conjunction with a posterior extraction or scheduled outpatient facility procedure, or as medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma. Panoramic x-rays may be taken once every two years for patients who cannot cooperate for intraoral film due to a developmental disability or medical condition that does not allow for intraoral film placement;

(7) prophylaxis, limited to one per year;

(8) application of fluoride varnish, limited to one per year;

(9) posterior fillings, all at the amalgam rate;

(10) anterior fillings;

(11) endodontics, limited to root canals on the anterior and premolars only;

(12) removable prostheses, each dental arch limited to one every six years;

(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;

(14) palliative treatment and sedative fillings for relief of pain; and

(15) full-mouth debridement, limited to one every five years.

(c) In addition to the services specified in paragraph (b), medical assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:

(1) periodontics, limited to periodontal scaling and root planing once every two years;

(2) general anesthesia; and

(3) full-mouth survey once every five years.

(d) Medical assistance covers dental services for children that are medically necessary. The following guidelines apply:

(1) posterior fillings are paid at the amalgam rate;

(2) application of sealants once every five years per permanent molar; and

(3) application of fluoride varnish once every six months.

EFFECTIVE DATE. This section is effective January 1, 2010.

Sec. 23. Minnesota Statutes 2008, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. Effective July 1, 2008, the actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus ~~14~~ 15 percent. The actual acquisition

94.1 cost of antihemophilic factor drugs shall be estimated at the average wholesale price
94.2 minus 30 percent. The maximum allowable cost of a multisource drug may be set by the
94.3 commissioner and it shall be comparable to, but no higher than, the maximum amount
94.4 paid by other third-party payors in this state who have maximum allowable cost programs.
94.5 Establishment of the amount of payment for drugs shall not be subject to the requirements
94.6 of the Administrative Procedure Act.

94.7 (b) An additional dispensing fee of $.30 may be added to the dispensing fee paid
94.8 to pharmacists for legend drug prescriptions dispensed to residents of long-term care
94.9 facilities when a unit dose blister card system, approved by the department, is used. Under
94.10 this type of dispensing system, the pharmacist must dispense a 30-day supply of drug.
94.11 The National Drug Code (NDC) from the drug container used to fill the blister card must
94.12 be identified on the claim to the department. The unit dose blister card containing the
94.13 drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700,
94.14 that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider
94.15 will be required to credit the department for the actual acquisition cost of all unused
94.16 drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the
94.17 manufacturer's unopened package. The commissioner may permit the drug clozapine to be
94.18 dispensed in a quantity that is less than a 30-day supply.

94.19 (c) Whenever a generically equivalent product is available, payment shall be on the
94.20 basis of the actual acquisition cost of the generic drug, or on the maximum allowable cost
94.21 established by the commissioner.

94.22 (d) The basis for determining the amount of payment for drugs administered in an
94.23 outpatient setting shall be the lower of the usual and customary cost submitted by the
94.24 provider or the amount established for Medicare by the United States Department of
94.25 Health and Human Services pursuant to title XVIII, section 1847a of the federal Social
94.26 Security Act.

94.27 (e) The commissioner may negotiate lower reimbursement rates for specialty
94.28 pharmacy products than the rates specified in paragraph (a). The commissioner may
94.29 require individuals enrolled in the health care programs administered by the department
94.30 to obtain specialty pharmacy products from providers with whom the commissioner has
94.31 negotiated lower reimbursement rates. Specialty pharmacy products are defined as those
94.32 used by a small number of recipients or recipients with complex and chronic diseases
94.33 that require expensive and challenging drug regimens. Examples of these conditions
94.34 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis
94.35 C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms
94.36 of cancer. Specialty pharmaceutical products include injectable and infusion therapies,

biotechnology drugs, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

EFFECTIVE DATE. This section is effective July 1, 2009.

Sec. 24. Minnesota Statutes 2008, section 256B.0625, subdivision 17, is amended to read:

Subd. 17. **Transportation costs.** (a) Medical assistance covers transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by eligible persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, common carrier, or other recognized providers of transportation services.

(b) Medical assistance covers special transportation, as defined in Minnesota Rules, part 9505.0315, subpart 1, item F, if the recipient has a physical or mental impairment that would prohibit the recipient from safely accessing and using a bus, taxi, other commercial transportation, or private automobile.

The commissioner may use an order by the recipient's attending physician to certify that the recipient requires special transportation services. Special transportation includes driver-assisted service to eligible individuals. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs or stretchers in the vehicle. Special transportation providers must obtain written documentation from the health care service provider who is serving the recipient being transported, identifying the time that the recipient arrived. Special transportation providers may not bill for separate base rates for the continuation of a trip beyond the original destination. Special transportation providers must take recipients to the nearest appropriate health care provider, using the most direct route available. The maximum medical assistance reimbursement rates for special transportation services are:

(1) $17 for the base rate and ~~$1.35~~ $1.65 per mile for services to eligible persons who need a wheelchair-accessible van;

96.1 (2) ~~$11.50~~ $8.50 for the base rate and $1.30 per mile for services to eligible persons
96.2 who do not need a wheelchair-accessible van; and
96.3 (3) $60 for the base rate and $2.40 per mile, and an attendant rate of $9 per trip, for
96.4 services to eligible persons who need a stretcher-accessible vehicle.

96.5 Sec. 25. Minnesota Statutes 2008, section 256B.0625, subdivision 26, is amended to
96.6 read:
96.7 Subd. 26. **Special education services.** (a) Medical assistance covers medical
96.8 services identified in a recipient's individualized education plan and covered under the
96.9 medical assistance state plan. Covered services include occupational therapy, physical
96.10 therapy, speech-language therapy, clinical psychological services, nursing services,
96.11 school psychological services, school social work services, personal care assistants
96.12 serving as management aides, assistive technology devices, transportation services,
96.13 health assessments, and other services covered under the medical assistance state plan.
96.14 Mental health services eligible for medical assistance reimbursement must be provided or
96.15 coordinated through a children's mental health collaborative where a collaborative exists if
96.16 the child is included in the collaborative operational target population. The provision or
96.17 coordination of services does not require that the individual education plan be developed
96.18 by the collaborative.
96.19 The services may be provided by a Minnesota school district that is enrolled as a
96.20 medical assistance provider or its subcontractor, and only if the services meet all the
96.21 requirements otherwise applicable if the service had been provided by a provider other
96.22 than a school district, in the following areas: medical necessity, physician's orders,
96.23 documentation, personnel qualifications, and prior authorization requirements. The
96.24 nonfederal share of costs for services provided under this subdivision is the responsibility
96.25 of the local school district as provided in section 125A.74. Services listed in a child's
96.26 individual education plan are eligible for medical assistance reimbursement only if those
96.27 services meet criteria for federal financial participation under the Medicaid program.
96.28 (b) Approval of health-related services for inclusion in the individual education plan
96.29 does not require prior authorization for purposes of reimbursement under this chapter.
96.30 The commissioner may require physician review and approval of the plan not more than
96.31 once annually or upon any modification of the individual education plan that reflects a
96.32 change in health-related services.
96.33 (c) Services of a speech-language pathologist provided under this section are covered
96.34 notwithstanding Minnesota Rules, part 9505.0390, subpart 1, item L, if the person:
96.35 (1) holds a masters degree in speech-language pathology;

97.1 (2) is licensed by the Minnesota Board of Teaching as an educational
97.2 speech-language pathologist; and

97.3 (3) either has a certificate of clinical competence from the American Speech and
97.4 Hearing Association, has completed the equivalent educational requirements and work
97.5 experience necessary for the certificate or has completed the academic program and is
97.6 acquiring supervised work experience to qualify for the certificate.

97.7 (d) Medical assistance coverage for medically necessary services provided under
97.8 other subdivisions in this section may not be denied solely on the basis that the same or
97.9 similar services are covered under this subdivision.

97.10 (e) The commissioner shall develop and implement package rates, bundled rates, or
97.11 per diem rates for special education services under which separately covered services are
97.12 grouped together and billed as a unit in order to reduce administrative complexity.

97.13 (f) The commissioner shall develop a cost-based payment structure for payment
97.14 of these services. The commissioner shall reimburse claims submitted based on an
97.15 interim rate, and shall settle at a final rate once the department has determined it. The
97.16 commissioner shall notify the school district of the final rate. The school district has 60
97.17 days to appeal the final rate. To appeal the final rate, the school district shall file a written
97.18 appeal request to the commissioner within 60 days of the date the final rate determination
97.19 was mailed. The appeal request shall specify (1) the disputed items and (2) the name and
97.20 address of the person to contact regarding the appeal.

97.21 (g) Effective July 1, 2000, medical assistance services provided under an individual
97.22 education plan or an individual family service plan by local school districts shall not count
97.23 against medical assistance authorization thresholds for that child.

97.24 (h) Nursing services as defined in section 148.171, subdivision 15, and provided
97.25 as an individual education plan health-related service, are eligible for medical assistance
97.26 payment if they are otherwise a covered service under the medical assistance program.
97.27 Medical assistance covers the administration of prescription medications by a licensed
97.28 nurse who is employed by or under contract with a school district when the administration
97.29 of medications is identified in the child's individualized education plan. The simple
97.30 administration of medications alone is not covered under medical assistance when
97.31 administered by a provider other than a school district or when it is not identified in the
97.32 child's individualized education plan.

97.33 Sec. 26. Minnesota Statutes 2008, section 256B.0631, subdivision 1, is amended to
97.34 read:

98.1 Subdivision 1. **Co-payments.** (a) Except as provided in subdivision 2, the medical
98.2 assistance benefit plan shall include the following co-payments for all recipients, effective
98.3 for services provided on or after ~~October 1, 2003, and before January 1, 2009~~ July 1, 2009:
98.4 (1) $3 per nonpreventive visit. For purposes of this subdivision, a visit means an
98.5 episode of service which is required because of a recipient's symptoms, diagnosis, or
98.6 established illness, and which is delivered in an ambulatory setting by a physician or
98.7 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
98.8 audiologist, optician, or optometrist;
98.9 (2) $3 for eyeglasses;
98.10 (3) $6 for nonemergency visits to a hospital-based emergency room; ~~and~~
98.11 ~~(4) $3 per brand-name drug prescription and $1 per generic drug prescription,~~
98.12 ~~subject to a $12 per month maximum for prescription drug co-payments. No co-payments~~
98.13 ~~shall apply to antipsychotic drugs when used for the treatment of mental illness.~~
98.14 ~~(b) Except as provided in subdivision 2, the medical assistance benefit plan shall~~
98.15 ~~include the following co-payments for all recipients, effective for services provided on~~
98.16 ~~or after January 1, 2009:~~
98.17 ~~(1) $6 for nonemergency visits to a hospital-based emergency room;~~
98.18 ~~(2)~~ (4) $3 per brand-name drug prescription and $1 per generic drug prescription,
98.19 subject to a $7 per month maximum for prescription drug co-payments. No co-payments
98.20 shall apply to antipsychotic drugs when used for the treatment of mental illness; and
98.21 ~~(3)~~ (5) for individuals identified by the commissioner with income at or below 100
98.22 percent of the federal poverty guidelines, total monthly co-payments must not exceed five
98.23 percent of family income. For purposes of this paragraph, family income is the total
98.24 earned and unearned income of the individual and the individual's spouse, if the spouse is
98.25 enrolled in medical assistance and also subject to the five percent limit on co-payments.
98.26 ~~(c)~~ (b) Recipients of medical assistance are responsible for all co-payments in this
98.27 subdivision.

98.28 Sec. 27. **[256B.0755] PAYMENT REFORM DEMONSTRATION PROJECT FOR**
98.29 **SPECIAL PATIENT POPULATIONS.**
98.30 Subdivision 1. **Demonstration project.** (a) The commissioner of human services,
98.31 in consultation with the commissioner of health, shall establish a payment reform
98.32 demonstration project implementing an alternative payment system for health care
98.33 providers serving an identified group of patients who are enrolled in a state health
98.34 care program, and are either high utilizers of high-cost health care services or have
98.35 characteristics that put them at high risk of becoming high utilizers. The purpose of the

99.1 demonstration project is to implement and evaluate methods of reducing hospitalizations,
99.2 emergency room use, high-cost medications and specialty services, admissions to nursing
99.3 facilities, or use of long-term home and community-based services, in order to reduce the
99.4 total cost of care and services for the patients.

99.5 (b) The commissioner shall give the highest priority to projects that will serve
99.6 patients who have chronic medical conditions or complex medical needs that are
99.7 complicated by a physical disability, serious mental illness, or serious socioeconomic
99.8 factors such as poverty, homelessness, or language or cultural barriers. The commissioner
99.9 shall also give the highest priority to providers or groups of providers who have the
99.10 highest concentrations of patients with these characteristics.

99.11 (c) The commissioner must implement this payment reform demonstration project
99.12 in a manner consistent with the payment reform initiative provided in sections 62U.02
99.13 to 62U.04.

99.14 (d) For purposes of this section, "state health care program" means the medical
99.15 assistance, MinnesotaCare, and general assistance medical care programs.

99.16 Subd. 2. **Participation.** (a) The commissioner shall request eligible providers or
99.17 groups of providers to submit a proposal to participate in the demonstration project by
99.18 September 1, 2009. The providers who are interested in participating shall negotiate with
99.19 the commissioner to determine:

99.20 (1) the identified group of patients who are to be enrolled in the program;

99.21 (2) the services that are to be included in the total cost of care calculation;

99.22 (3) the methodology for calculating the total cost of care, which may take into
99.23 consideration the impact on costs to other state or local government programs including,
99.24 but not limited to, social services and income maintenance programs;

99.25 (4) the time period to be covered under the bid;

99.26 (5) the implementation of a risk adjustment mechanism to adjust for factors that are
99.27 beyond the control of the provider including nonclinical factors that will affect the cost
99.28 or outcomes of treatment;

99.29 (6) the payment reforms and payment methods to be used under the project, which
99.30 may include but are not limited to adjustments in fee-for-service payments, payment of
99.31 care coordination fees, payments for start-up and implementation costs to be recovered or
99.32 repaid later in the project, payments adjusted based on a provider's proportion of patients
99.33 who are enrolled in state health care programs; payments adjusted for the clinical or
99.34 socioeconomic complexity of the patients served, payment incentives tied to use of
99.35 inpatient and emergency room services, and periodic settle-up adjustments;

100.1 (7) methods of sharing financial risk and benefit between the commissioner and
100.2 the provider or groups of providers, which may include but are not limited to stop-loss
100.3 arrangements to cover high-cost outlier cases or costs that are beyond the control of the
100.4 provider, and risk-sharing and benefit-sharing corridors; and
100.5 (8) performance and outcome benchmarks to be used to measure performance,
100.6 achievement of cost-savings targets, and quality of care provided.
100.7 (b) A provider or group of providers may submit a proposal for a demonstration
100.8 project in partnership with a health maintenance organization or county-based purchasing
100.9 plan for the purposes of sharing risk, claims processing, or administration of the project,
100.10 or to extend participation in the project to persons who are enrolled in prepaid health
100.11 care programs.
100.12 Subd. 3. **Total cost of care agreement.** Based on negotiations, the commissioner
100.13 must enter into an agreement with interested and eligible providers or groups of providers
100.14 to implement projects that are designed to reduce the total cost of care for the identified
100.15 patients. To the extent possible, the projects shall begin implementation on January 1,
100.16 2010, or upon federal approval, whichever is later.
100.17 Subd. 4. **Eligibility.** To be eligible to participate, providers or groups of providers
100.18 must meet certification standards for health care homes established by the Department of
100.19 Health and the Department of Human Services under section 256B.0751.
100.20 Subd. 5. **Alternative payments.** The commissioner shall seek all federal waivers
100.21 and approvals necessary to implement this section and to obtain federal matching funds. To
100.22 the extent authorized by federal law, the commissioner may waive existing fee-for-service
100.23 payment rates, provider contract or performance requirements, consumer incentive
100.24 policies, or other requirements in statute or rule in order to allow the providers or groups
100.25 of providers to utilize alternative payment and financing methods that will appropriately
100.26 fund necessary and cost-effective primary care and care coordination services; establish
100.27 appropriate incentives for prevention, health promotion, and care coordination; and
100.28 mitigate financial harm to participating providers caused by the successful reduction in
100.29 preventable hospitalization, emergency room use, and other costly services.
100.30 Subd. 6. **Cost neutrality.** The total cost, including administrative costs, of this
100.31 demonstration project must not exceed the costs that would otherwise be incurred by
100.32 the state had services to the state health care program enrollees participating in the
100.33 demonstration project been provided, as applicable for the enrollee, under fee-for-service
100.34 or through managed care or county-based purchasing plans.

101.1 Sec. 28. Minnesota Statutes 2008, section 256B.08, is amended by adding a
101.2 subdivision to read:

101.3 Subd. 4. **Data from Social Security.** The commissioner shall accept data from the
101.4 Social Security Administration in accordance with United States Code, title 42, section
101.5 1396U-5(a).

101.6 **EFFECTIVE DATE.** This section is effective January 1, 2010.

101.7 Sec. 29. Minnesota Statutes 2008, section 256B.15, subdivision 1, is amended to read:

101.8 Subdivision 1. **Policy and applicability.** (a) It is the policy of this state that
101.9 individuals or couples, either or both of whom participate in the medical assistance
101.10 program, use their own assets to pay their share of the total cost of their care during or
101.11 after their enrollment in the program according to applicable federal law and the laws of
101.12 this state. The following provisions apply:

101.13 (1) subdivisions 1c to 1k shall not apply to claims arising under this section which
101.14 are presented under section 525.313;

101.15 (2) the provisions of subdivisions 1c to 1k expanding the interests included in an
101.16 estate for purposes of recovery under this section give effect to the provisions of United
101.17 States Code, title 42, section 1396p, governing recoveries, but do not give rise to any
101.18 express or implied liens in favor of any other parties not named in these provisions;

101.19 (3) the continuation of a recipient's life estate or joint tenancy interest in real
101.20 property after the recipient's death for the purpose of recovering medical assistance under
101.21 this section modifies common law principles holding that these interests terminate on
101.22 the death of the holder;

101.23 (4) all laws, rules, and regulations governing or involved with a recovery of medical
101.24 assistance shall be liberally construed to accomplish their intended purposes;

101.25 (5) a deceased recipient's life estate and joint tenancy interests continued under this
101.26 section shall be owned by the remaindermen or surviving joint tenants as their interests
101.27 may appear on the date of the recipient's death. They shall not be merged into the
101.28 remainder interest or the interests of the surviving joint tenants by reason of ownership.
101.29 They shall be subject to the provisions of this section. Any conveyance, transfer, sale,
101.30 assignment, or encumbrance by a remainderman, a surviving joint tenant, or their heirs,
101.31 successors, and assigns shall be deemed to include all of their interest in the deceased
101.32 recipient's life estate or joint tenancy interest continued under this section; and

101.33 (6) the provisions of subdivisions 1c to 1k continuing a recipient's joint tenancy
101.34 interests in real property after the recipient's death do not apply to a homestead owned
101.35 of record, on the date the recipient dies, by the recipient and the recipient's spouse as

102.1 joint tenants with a right of survivorship. Homestead means the real property occupied
102.2 by the surviving joint tenant spouse as their sole residence on the date the recipient dies
102.3 and classified and taxed to the recipient and surviving joint tenant spouse as homestead
102.4 property for property tax purposes in the calendar year in which the recipient dies. For
102.5 purposes of this exemption, real property the recipient and their surviving joint tenant
102.6 spouse purchase solely with the proceeds from the sale of their prior homestead, own
102.7 of record as joint tenants, and qualify as homestead property under section 273.124 in
102.8 the calendar year in which the recipient dies and prior to the recipient's death shall be
102.9 deemed to be real property classified and taxed to the recipient and their surviving joint
102.10 tenant spouse as homestead property in the calendar year in which the recipient dies.
102.11 The surviving spouse, or any person with personal knowledge of the facts, may provide
102.12 an affidavit describing the homestead property affected by this clause and stating facts
102.13 showing compliance with this clause. The affidavit shall be prima facie evidence of the
102.14 facts it states.

102.15 (b) For purposes of this section, "medical assistance" includes the medical assistance
102.16 program under this chapter and the general assistance medical care program under chapter
102.17 256D and alternative care for nonmedical assistance recipients under section 256B.0913.

102.18 (c) For purposes of this section, beginning January 1, 2010, "medical assistance"
102.19 does not include Medicare cost-sharing benefits in accordance with United States Code,
102.20 title 42, section 1396p.

102.21 ~~(c)~~ (d) All provisions in this subdivision, and subdivisions 1d, 1f, 1g, 1h, 1i, and
102.22 1j, related to the continuation of a recipient's life estate or joint tenancy interests in real
102.23 property after the recipient's death for the purpose of recovering medical assistance, are
102.24 effective only for life estates and joint tenancy interests established on or after August 1,
102.25 2003. For purposes of this paragraph, medical assistance does not include alternative care.

102.26 Sec. 30. Minnesota Statutes 2008, section 256B.15, subdivision 1a, is amended to read:

102.27 Subd. 1a. **Estates subject to claims.** (a) If a person receives any medical assistance
102.28 hereunder, on the person's death, if single, or on the death of the survivor of a married
102.29 couple, either or both of whom received medical assistance, or as otherwise provided
102.30 for in this section, the total amount paid for medical assistance rendered for the person
102.31 and spouse shall be filed as a claim against the estate of the person or the estate of the
102.32 surviving spouse in the court having jurisdiction to probate the estate or to issue a decree
102.33 of descent according to sections 525.31 to 525.313.

102.34 (b) For the purposes of this section, the person's estate must consist of:

102.35 (1) the person's probate estate;

103.1 (2) all of the person's interests or proceeds of those interests in real property the
103.2 person owned as a life tenant or as a joint tenant with a right of survivorship at the time of
103.3 the person's death;
103.4 (3) all of the person's interests or proceeds of those interests in securities the person
103.5 owned in beneficiary form as provided under sections 524.6-301 to 524.6-311 at the time
103.6 of the person's death, to the extent the interests or proceeds of those interests become part
103.7 of the probate estate under section 524.6-307;
103.8 (4) all of the person's interests in joint accounts, multiple-party accounts, and
103.9 pay-on-death accounts, brokerage accounts, investment accounts, or the proceeds of
103.10 those accounts, as provided under sections 524.6-201 to 524.6-214 at the time of the
103.11 person's death to the extent the interests become part of the probate estate under section
103.12 524.6-207; and
103.13 (5) assets conveyed to a survivor, heir, or assign of the person through survivorship,
103.14 living trust, or other arrangements.
103.15 (c) For the purpose of this section and recovery in a surviving spouse's estate for
103.16 medical assistance paid for a predeceased spouse, the estate must consist of all of the legal
103.17 title and interests the deceased individual's predeceased spouse had in jointly owned or
103.18 marital property at the time of the spouse's death, as defined in subdivision 2b, and the
103.19 proceeds of those interests, that passed to the deceased individual or another individual, a
103.20 survivor, an heir, or an assign of the predeceased spouse through a joint tenancy, tenancy
103.21 in common, survivorship, life estate, living trust, or other arrangement. A deceased
103.22 recipient who, at death, owned the property jointly with the surviving spouse shall have
103.23 an interest in the entire property.
103.24 (d) For the purpose of recovery in a single person's estate or the estate of a survivor
103.25 of a married couple, "other arrangement" includes any other means by which title to all or
103.26 any part of the jointly owned or marital property or interest passed from the predeceased
103.27 spouse to another including, but not limited to, transfers between spouses which are
103.28 permitted, prohibited, or penalized for purposes of medical assistance.
103.29 (e) A claim shall be filed if medical assistance was rendered for either or both
103.30 persons under one of the following circumstances:
103.31 ~~(a)~~ (1) the person was over 55 years of age, and received services under this chapter;
103.32 ~~(b)~~ (2) the person resided in a medical institution for six months or longer, received
103.33 services under this chapter, and, at the time of institutionalization or application for
103.34 medical assistance, whichever is later, the person could not have reasonably been expected
103.35 to be discharged and returned home, as certified in writing by the person's treating
103.36 physician. For purposes of this section only, a "medical institution" means a skilled

nursing facility, intermediate care facility, intermediate care facility for persons with developmental disabilities, nursing facility, or inpatient hospital; or

~~(c)~~ (3) the person received general assistance medical care services under chapter 256D.

(f) The claim shall be considered an expense of the last illness of the decedent for the purpose of section 524.3-805. Notwithstanding any law or rule to the contrary, a state or county agency with a claim under this section must be a creditor under section 524.6-307. Any statute of limitations that purports to limit any county agency or the state agency, or both, to recover for medical assistance granted hereunder shall not apply to any claim made hereunder for reimbursement for any medical assistance granted hereunder. Notice of the claim shall be given to all heirs and devisees of the decedent whose identity can be ascertained with reasonable diligence. The notice must include procedures and instructions for making an application for a hardship waiver under subdivision 5; time frames for submitting an application and determination; and information regarding appeal rights and procedures. Counties are entitled to one-half of the nonfederal share of medical assistance collections from estates that are directly attributable to county effort. Counties are entitled to ten percent of the collections for alternative care directly attributable to county effort.

Sec. 31. Minnesota Statutes 2008, section 256B.15, subdivision 1h, is amended to read:

Subd. 1h. **Estates of specific persons receiving medical assistance.** (a) For purposes of this section, paragraphs (b) to ~~(k)~~ (j) apply if a person received medical assistance for which a claim may be filed under this section and died single, or the surviving spouse of the couple and was not survived by any of the persons described in subdivisions 3 and 4.

~~(b) For purposes of this section, the person's estate consists of: (1) the person's probate estate; (2) all of the person's interests or proceeds of those interests in real property the person owned as a life tenant or as a joint tenant with a right of survivorship at the time of the person's death; (3) all of the person's interests or proceeds of those interests in securities the person owned in beneficiary form as provided under sections 524.6-301 to 524.6-311 at the time of the person's death, to the extent they become part of the probate estate under section 524.6-307; (4) all of the person's interests in joint accounts, multiple party accounts, and pay on death accounts, or the proceeds of those accounts, as provided under sections 524.6-201 to 524.6-214 at the time of the person's death to the extent they become part of the probate estate under section 524.6-207; and (5) the person's legal title or interest at the time of the person's death in real property transferred under a transfer on death deed under section 507.071, or in the proceeds from the subsequent~~

105.1 ~~sale of the person's interest in the real property. Notwithstanding any law or rule to the~~
105.2 ~~contrary, a state or county agency with a claim under this section shall be a creditor under~~
105.3 ~~section 524.6-307.~~

105.4 ~~(c)~~ (b) Notwithstanding any law or rule to the contrary, the person's life estate or joint
105.5 tenancy interest in real property not subject to a medical assistance lien under sections
105.6 514.980 to 514.985 on the date of the person's death shall not end upon the person's death
105.7 and shall continue as provided in this subdivision. The life estate in the person's estate
105.8 shall be that portion of the interest in the real property subject to the life estate that is equal
105.9 to the life estate percentage factor for the life estate as listed in the Life Estate Mortality
105.10 Table of the health care program's manual for a person who was the age of the medical
105.11 assistance recipient on the date of the person's death. The joint tenancy interest in real
105.12 property in the estate shall be equal to the fractional interest the person would have owned
105.13 in the jointly held interest in the property had they and the other owners held title to the
105.14 property as tenants in common on the date the person died.

105.15 ~~(d)~~ (c) The court upon its own motion, or upon motion by the personal representative
105.16 or any interested party, may enter an order directing the remaindermen or surviving joint
105.17 tenants and their spouses, if any, to sign all documents, take all actions, and otherwise
105.18 fully cooperate with the personal representative and the court to liquidate the decedent's
105.19 life estate or joint tenancy interests in the estate and deliver the cash or the proceeds of
105.20 those interests to the personal representative and provide for any legal and equitable
105.21 sanctions as the court deems appropriate to enforce and carry out the order, including an
105.22 award of reasonable attorney fees.

105.23 ~~(e)~~ (d) The personal representative may make, execute, and deliver any conveyances
105.24 or other documents necessary to convey the decedent's life estate or joint tenancy interest
105.25 in the estate that are necessary to liquidate and reduce to cash the decedent's interest or
105.26 for any other purposes.

105.27 ~~(f)~~ (e) Subject to administration, all costs, including reasonable attorney fees,
105.28 directly and immediately related to liquidating the decedent's life estate or joint tenancy
105.29 interest in the decedent's estate, shall be paid from the gross proceeds of the liquidation
105.30 allocable to the decedent's interest and the net proceeds shall be turned over to the personal
105.31 representative and applied to payment of the claim presented under this section.

105.32 ~~(g)~~ (f) The personal representative shall bring a motion in the district court in which
105.33 the estate is being probated to compel the remaindermen or surviving joint tenants to
105.34 account for and deliver to the personal representative all or any part of the proceeds of any
105.35 sale, mortgage, transfer, conveyance, or any disposition of real property allocable to the
105.36 decedent's life estate or joint tenancy interest in the decedent's estate, and do everything

106.1 necessary to liquidate and reduce to cash the decedent's interest and turn the proceeds of
106.2 the sale or other disposition over to the personal representative. The court may grant any
106.3 legal or equitable relief including, but not limited to, ordering a partition of real estate
106.4 under chapter 558 necessary to make the value of the decedent's life estate or joint tenancy
106.5 interest available to the estate for payment of a claim under this section.

106.6 ~~(h)~~ (g) Subject to administration, the personal representative shall use all of the cash
106.7 or proceeds of interests to pay an allowable claim under this section. The remaindermen
106.8 or surviving joint tenants and their spouses, if any, may enter into a written agreement
106.9 with the personal representative or the claimant to settle and satisfy obligations imposed at
106.10 any time before or after a claim is filed.

106.11 ~~(i)~~ (h) The personal representative may, at their discretion, provide any or all of the
106.12 other owners, remaindermen, or surviving joint tenants with an affidavit terminating the
106.13 decedent's estate's interest in real property the decedent owned as a life tenant or as a joint
106.14 tenant with others, if the personal representative determines in good faith that neither the
106.15 decedent nor any of the decedent's predeceased spouses received any medical assistance
106.16 for which a claim could be filed under this section, or if the personal representative has
106.17 filed an affidavit with the court that the estate has other assets sufficient to pay a claim, as
106.18 presented, or if there is a written agreement under paragraph ~~(h)~~ (g), or if the claim, as
106.19 allowed, has been paid in full or to the full extent of the assets the estate has available
106.20 to pay it. The affidavit may be recorded in the office of the county recorder or filed in
106.21 the Office of the Registrar of Titles for the county in which the real property is located.
106.22 Except as provided in section 514.981, subdivision 6, when recorded or filed, the affidavit
106.23 shall terminate the decedent's interest in real estate the decedent owned as a life tenant or a
106.24 joint tenant with others. The affidavit shall:

106.25 (1) be signed by the personal representative;

106.26 (2) identify the decedent and the interest being terminated;

106.27 (3) give recording information sufficient to identify the instrument that created the
106.28 interest in real property being terminated;

106.29 (4) legally describe the affected real property;

106.30 (5) state that the personal representative has determined that neither the decedent
106.31 nor any of the decedent's predeceased spouses received any medical assistance for which
106.32 a claim could be filed under this section;

106.33 (6) state that the decedent's estate has other assets sufficient to pay the claim, as
106.34 presented, or that there is a written agreement between the personal representative and
106.35 the claimant and the other owners or remaindermen or other joint tenants to satisfy the
106.36 obligations imposed under this subdivision; and

107.1 (7) state that the affidavit is being given to terminate the estate's interest under this
107.2 subdivision, and any other contents as may be appropriate.

107.3 The recorder or registrar of titles shall accept the affidavit for recording or filing. The
107.4 affidavit shall be effective as provided in this section and shall constitute notice even if it
107.5 does not include recording information sufficient to identify the instrument creating the
107.6 interest it terminates. The affidavit shall be conclusive evidence of the stated facts.

107.7 ~~(j)~~ (i) The holder of a lien arising under subdivision 1c shall release the lien at
107.8 the holder's expense against an interest terminated under paragraph ~~(h)~~ (g) to the extent
107.9 of the termination.

107.10 ~~(k)~~ (j) If a lien arising under subdivision 1c is not released under paragraph ~~(j)~~ (i),
107.11 prior to closing the estate, the personal representative shall deed the interest subject to the
107.12 lien to the remaindermen or surviving joint tenants as their interests may appear. Upon
107.13 recording or filing, the deed shall work a merger of the recipient's life estate or joint
107.14 tenancy interest, subject to the lien, into the remainder interest or interest the decedent and
107.15 others owned jointly. The lien shall attach to and run with the property to the extent of
107.16 the decedent's interest at the time of the decedent's death.

107.17 Sec. 32. Minnesota Statutes 2008, section 256B.15, subdivision 2, is amended to read:

107.18 Subd. 2. **Limitations on claims.** The claim shall include only the total amount
107.19 of medical assistance rendered after age 55 or during a period of institutionalization
107.20 described in subdivision 1a, ~~clause (b)~~ paragraph (e), and the total amount of general
107.21 assistance medical care rendered, and shall not include interest. Claims that have been
107.22 allowed but not paid shall bear interest according to section 524.3-806, paragraph (d). A
107.23 claim against the estate of a surviving spouse who did not receive medical assistance, for
107.24 medical assistance rendered for the predeceased spouse, shall be payable from the full
107.25 value of all of the predeceased spouse's assets and interests which are part of the surviving
107.26 spouse's estate under subdivisions 1a and 2b. Recovery of medical assistance expenses in
107.27 the nonrecipient surviving spouse's estate is limited to the value of the assets of the estate
107.28 that were marital property or jointly owned property at any time during the marriage. The
107.29 claim is not payable from the value of assets or proceeds of assets in the estate attributable
107.30 to a predeceased spouse whom the individual married after the death of the predeceased
107.31 recipient spouse for whom the claim is filed or from assets and the proceeds of assets in the
107.32 estate which the nonrecipient decedent spouse acquired with assets which were not marital
107.33 property or jointly owned property after the death of the predeceased recipient spouse.
107.34 Claims for alternative care shall be net of all premiums paid under section 256B.0913,
107.35 subdivision 12, on or after July 1, 2003, and shall be limited to services provided on or

108.1 after July 1, 2003. Claims against marital property shall be limited to claims against
108.2 recipients who died on or after July 1, 2009.

108.3 Sec. 33. Minnesota Statutes 2008, section 256B.15, is amended by adding a
108.4 subdivision to read:

108.5 Subd. 2b. **Controlling provisions.** (a) For purposes of this subdivision and
108.6 subdivisions 1a and 2, paragraphs (b) to (d) apply.

108.7 (b) At the time of death of a recipient spouse and solely for purpose of recovery of
108.8 medical assistance benefits received, a predeceased recipient spouse shall have a legal
108.9 title or interest in the undivided whole of all of the property which the recipient and the
108.10 recipient's surviving spouse owned jointly or which was marital property at any time
108.11 during their marriage regardless of the form of ownership and regardless of whether
108.12 it was owned or titled in the names of one or both the recipient and the recipient's
108.13 spouse. Title and interest in the property of a predeceased recipient spouse shall not end
108.14 or extinguish upon the person's death and shall continue for the purpose of allowing
108.15 recovery of medical assistance in the estate of the surviving spouse. Upon the death of
108.16 the predeceased recipient spouse, title and interest in the predeceased spouse's property
108.17 shall vest in the surviving spouse by operation of law and without the necessity for any
108.18 probate or decree of descent proceedings and shall continue to exist after the death of the
108.19 predeceased spouse and the surviving spouse to permit recovery of medical assistance.
108.20 The recipient spouse and the surviving spouse of a deceased recipient spouse shall not
108.21 encumber, disclaim, transfer, alienate, hypothecate, or otherwise divest themselves of
108.22 these interests before or upon death.

108.23 (c) For purposes of this section, "marital property" includes any and all real or
108.24 personal property of any kind or interests in such property the predeceased recipient
108.25 spouse and their spouse, or either of them, owned at the time of their marriage to each
108.26 other or acquired during their marriage regardless of whether it was owned or titled in
108.27 the names of one or both of them. If either or both spouses of a married couple received
108.28 medical assistance, all property owned during the marriage or which either or both spouses
108.29 acquired during their marriage shall be presumed to be marital property for purposes of
108.30 recovering medical assistance unless there is clear and convincing evidence to the contrary.

108.31 (d) The agency responsible for the claim for medical assistance for a recipient spouse
108.32 may, at its discretion, release specific real and personal property from the provisions of
108.33 this section. The release shall extinguish the interest created under paragraph (b) in the
108.34 land it describes upon filing or recording. The release need not be attested, certified, or
108.35 acknowledged as a condition of filing or recording and shall be filed or recorded in the

109.1 office of the county recorder or registrar of titles, as appropriate, in the county where the
109.2 real property is located. The party to whom the release is given shall be responsible for
109.3 paying all fees and costs necessary to record and file the release. If the property described
109.4 in the release is registered property, the registrar of titles shall accept it for recording and
109.5 shall record it on the certificate of title for each parcel of property described in the release.
109.6 If the property described in the release is abstract property, the recorder shall accept it
109.7 for filing and file it in the county's grantor-grantee indexes and any tract index the county
109.8 maintains for each parcel of property described in the release.

109.9 Sec. 34. Minnesota Statutes 2008, section 256B.15, is amended by adding a
109.10 subdivision to read:

109.11 Subd. 9. **Commissioner's intervention.** The commissioner shall be permitted to
109.12 intervene as a party in any proceeding involving recovery of medical assistance upon
109.13 filing a notice of intervention and serving such notice on the other parties.

109.14 Sec. 35. Minnesota Statutes 2008, section 256B.69, subdivision 5a, is amended to read:

109.15 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section
109.16 and sections 256L.12 and 256D.03, shall be entered into or renewed on a calendar year
109.17 basis beginning January 1, 1996. Managed care contracts which were in effect on June
109.18 30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995
109.19 through December 31, 1995 at the same terms that were in effect on June 30, 1995. The
109.20 commissioner may issue separate contracts with requirements specific to services to
109.21 medical assistance recipients age 65 and older.

109.22 (b) A prepaid health plan providing covered health services for eligible persons
109.23 pursuant to chapters 256B, 256D, and 256L, is responsible for complying with the terms
109.24 of its contract with the commissioner. Requirements applicable to managed care programs
109.25 under chapters 256B, 256D, and 256L, established after the effective date of a contract
109.26 with the commissioner take effect when the contract is next issued or renewed.

109.27 (c) Effective for services rendered on or after January 1, 2003, the commissioner shall
109.28 withhold five percent of managed care plan payments under this section and county-based
109.29 purchasing plan's payment rate under section 256B.692 for the prepaid medical assistance
109.30 and general assistance medical care programs pending completion of performance targets.
109.31 Each performance target must be quantifiable, objective, measurable, and reasonably
109.32 attainable, except in the case of a performance target based on a federal or state law or rule.
109.33 Criteria for assessment of each performance target must be outlined in writing prior to the
109.34 contract effective date. The managed care plan must demonstrate, to the commissioner's

satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23. ~~A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this paragraph that is reasonably expected to be returned.~~

(d)~~(1)~~ Effective for services rendered on or after January 1, 2009, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance and general assistance medical care programs. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

~~(2) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this paragraph.~~ The return of the withhold under this paragraph is not subject to the requirements of paragraph (c).

(e) Effective for services rendered on or after January 1, 2010, the commissioner shall include as part of the performance targets described in paragraph (a) a reduction in the health plan's emergency room utilization rate for state health care program enrollees by a measurable rate of five percent from the plan's utilization rate for state health care program enrollees for the previous calendar year.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved.

The withhold described in this paragraph shall continue for each consecutive contract period until the health plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the health plan's emergency room utilization rate for state health care program enrollees for calendar year 2008.

(f) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

Sec. 36. Minnesota Statutes 2008, section 256B.69, subdivision 5c, is amended to read:

Subd. 5c. **Medical education and research fund.** (a) Except as provided in paragraph (c), the commissioner of human services shall transfer each year to the medical education and research fund established under section 62J.692, the following:

(1) an amount equal to the reduction in the prepaid medical assistance and prepaid general assistance medical care payments as specified in this clause. Until January 1, 2002, the county medical assistance and general assistance medical care capitation base rate prior to plan specific adjustments and after the regional rate adjustments under section 256B.69, subdivision 5b, is reduced 6.3 percent for Hennepin County, two percent for the remaining metropolitan counties, and no reduction for nonmetropolitan Minnesota counties; and after January 1, 2002, the county medical assistance and general assistance medical care capitation base rate prior to plan specific adjustments is reduced 6.3 percent for Hennepin County, two percent for the remaining metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties. Nursing facility and elderly waiver payments and demonstration project payments operating under subdivision 23 are excluded from this reduction. The amount calculated under this clause shall not be adjusted for periods already paid due to subsequent changes to the capitation payments;

(2) beginning July 1, 2003, ~~$2,157,000~~ $4,314,000 from the capitation rates paid under this section ~~plus any federal matching funds on this amount~~;

(3) beginning July 1, 2002, an additional $12,700,000 from the capitation rates paid under this section; and

(4) beginning July 1, 2003, an additional $4,700,000 from the capitation rates paid under this section.

(b) This subdivision shall be effective upon approval of a federal waiver which allows federal financial participation in the medical education and research fund. Effective July 1, 2009, and thereafter, the transfers required by paragraph (a), clauses (1) to (4), shall not exceed the total amount transferred for fiscal year 2009. Any excess shall first reduce the amounts otherwise required to be transferred under paragraph (a), clauses (2), (3), and (4). Any excess following this reduction shall proportionally reduce the transfers under paragraph (a), clause (1).

112.1 (c) Effective July 1, 2003, the amount reduced from the prepaid general assistance
112.2 medical care payments under paragraph (a), clause (1), shall be transferred to the general
112.3 fund.

112.4 (d) Beginning July 1, 2009, of the amounts in paragraph (a), the commissioner shall
112.5 transfer $21,714,000 each fiscal year to the medical education and research fund. The
112.6 balance of the transfers under paragraph (a) shall be transferred to the medical education
112.7 and research fund no earlier than July 1 of the following fiscal year.

112.8 Sec. 37. Minnesota Statutes 2008, section 256B.69, subdivision 5f, is amended to read:

112.9 Subd. 5f. **Capitation rates.** (a) Beginning July 1, 2002, the capitation rates paid
112.10 under this section are increased by $12,700,000 per year. Beginning July 1, 2003, the
112.11 capitation rates paid under this section are increased by $4,700,000 per year.

112.12 (b) Beginning July 1, 2009, the capitation rates paid under this section are increased
112.13 each year by the lesser of $21,714,000 or an amount equal to the difference between the
112.14 estimated value of the reductions described in subdivision 5c, paragraph (a), clause (1),
112.15 and the amount of the limit described in subdivision 5c, paragraph (b).

112.16 Sec. 38. **[256B.695] PAYMENT FOR BASIC CARE SERVICES.**

112.17 Effective service date July 1, 2009, total payments for basic care services, except
112.18 prescription drugs, medical supplies, prosthetics, lab, radiology, medical transportation,
112.19 and services subject to or specifically exempted from section 256B.76, subdivision 1,
112.20 paragraph (c), shall be reduced by 3.0 percent, prior to third-party liability. Payments
112.21 made to managed care and county-based purchasing plans shall be reduced for services
112.22 provided on or after January 1, 2010, to reflect this reduction.

112.23 Sec. 39. Minnesota Statutes 2008, section 256B.76, subdivision 1, is amended to read:

112.24 Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on
112.25 or after October 1, 1992, the commissioner shall make payments for physician services
112.26 as follows:

112.27 (1) payment for level one Centers for Medicare and Medicaid Services' common
112.28 procedural coding system codes titled "office and other outpatient services," "preventive
112.29 medicine new and established patient," "delivery, antepartum, and postpartum care,"
112.30 "critical care," cesarean delivery and pharmacologic management provided to psychiatric
112.31 patients, and level three codes for enhanced services for prenatal high risk, shall be paid
112.32 at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June
112.33 30, 1992. If the rate on any procedure code within these categories is different than the

113.1 rate that would have been paid under the methodology in section 256B.74, subdivision 2,
113.2 then the larger rate shall be paid;

113.3 (2) payments for all other services shall be paid at the lower of (i) submitted charges,
113.4 or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

113.5 (3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th
113.6 percentile of 1989, less the percent in aggregate necessary to equal the above increases
113.7 except that payment rates for home health agency services shall be the rates in effect
113.8 on September 30, 1992.

113.9 (b) Effective for services rendered on or after January 1, 2000, payment rates for
113.10 physician and professional services shall be increased by three percent over the rates
113.11 in effect on December 31, 1999, except for home health agency and family planning
113.12 agency services. The increases in this paragraph shall be implemented January 1, 2000,
113.13 for managed care.

113.14 (c) Effective for services rendered on or after July 1, 2009, payment rates for
113.15 physician and professional services shall be reduced by three percent over the rates in effect
113.16 on June 30, 2009, except for office or other outpatient services (procedure codes 99201
113.17 to 99215) and preventive medicine services (procedure codes 99381 to 99412) billed by
113.18 the following primary care specialties: general practitioner, internal medicine, pediatrics,
113.19 geriatric nurse practitioner, pediatric nurse practitioner, family practice nurse practitioner,
113.20 adult nurse practitioner, geriatrics, and family practice. The commissioner, effective
113.21 January 1, 2010, shall reduce capitation rates paid to managed care and county-based
113.22 purchasing plans under sections 256B.69 and 256B.692 to reflect this payment reduction.

113.23 Sec. 40. Minnesota Statutes 2008, section 256B.76, subdivision 4, is amended to read:

113.24 Subd. 4. **Critical access dental providers.** Effective for dental services rendered
113.25 on or after January 1, 2002, the commissioner shall increase reimbursements to dentists
113.26 and dental clinics deemed by the commissioner to be critical access dental providers.
113.27 For dental services rendered on or after July 1, 2007, the commissioner shall increase
113.28 reimbursement by 30 percent above the reimbursement rate that would otherwise be paid to
113.29 the critical access dental provider. The commissioner shall pay the health plan companies
113.30 in amounts sufficient to reflect increased reimbursements to critical access dental providers
113.31 as approved by the commissioner. In determining which dentists and dental clinics shall
113.32 be deemed critical access dental providers, the commissioner shall review:

113.33 (1) the utilization rate in the service area in which the dentist or dental clinic operates
113.34 for dental services to patients covered by medical assistance, general assistance medical
113.35 care, or MinnesotaCare as their primary source of coverage;

114.1 (2) the level of services provided by the dentist or dental clinic to patients covered
114.2 by medical assistance, general assistance medical care, or MinnesotaCare as their primary
114.3 source of coverage; and

114.4 (3) whether the level of services provided by the dentist or dental clinic is critical to
114.5 maintaining adequate levels of patient access within the service area.

114.6 In the absence of a critical access dental provider in a service area, the commissioner may
114.7 designate a dentist or dental clinic as a critical access dental provider if the dentist or
114.8 dental clinic is willing to provide care to patients covered by medical assistance, general
114.9 assistance medical care, or MinnesotaCare at a level which significantly increases access
114.10 to dental care in the service area. The commissioner shall administer this subdivision
114.11 within the limits of available appropriations.

114.12 Sec. 41. Minnesota Statutes 2008, section 256B.76, is amended by adding a
114.13 subdivision to read:

114.14 Subd. 4a. **Designation and termination of critical access dental providers.** (a)
114.15 The commissioner shall not designate an individual dentist or clinic as a critical access
114.16 dental provider under subdivision 4 or section 256L.11, subdivision 7, when the owner or
114.17 any dentist employed by or under contract with the practice:

114.18 (1) has been subject to a corrective or disciplinary action by the Minnesota Board of
114.19 Dentistry within the past five years or is currently subject to a corrective or disciplinary
114.20 action by the board. Designation shall not be made until the provider is no longer subject
114.21 to a corrective or disciplinary action;

114.22 (2) does not bill on a clinic-specific location basis;

114.23 (3) has been subject, within the past five years, to a postinvestigation action by the
114.24 commissioner of human services or contracted health plan when investigating services
114.25 provided to Minnesota health care program enrollees, including administrative sanctions,
114.26 monetary recovery, referral to state regulatory agency, referral to the state attorney general
114.27 or county attorney general, or issuance of a warning as specified in Minnesota Rules, parts
114.28 9505.2160 to 9505.2245. Designation shall not be considered until the January of the
114.29 year following documentation that the activity that resulted in postinvestigative action
114.30 has stopped; or

114.31 (4) has not completed the application for critical access dental provider designation,
114.32 has submitted the application after the due date, provided incorrect information, or has
114.33 knowingly and willfully submitted a fraudulent designation form.

115.1 (b) The commissioner shall terminate a critical access designation of an individual
115.2 dentist or clinic, if the owner or any dentist employed by or under contract with the
115.3 practice:
115.4 (1) becomes subject to a disciplinary or corrective action by the Minnesota Board of
115.5 Dentistry. The provider shall not be considered for critical access designation until the
115.6 January following the year in which the action has ended; or
115.7 (2) becomes subject to a postinvestigation action by the commissioner of human
115.8 services or contracted health plan including administrative sanctions, monetary recovery,
115.9 referral to state regulatory agency, referral to the state attorney general or county attorney
115.10 general, or issuance of a warning as specified in Minnesota Rules, parts 9505.2160 to
115.11 9505.2245. Designation shall not be considered until the January of the year following
115.12 documentation that the activity that resulted in postinvestigative action has stopped.
115.13 (c) Any termination is retroactive to the date of the:
115.14 (1) postinvestigative action; or
115.15 (2) disciplinary or corrective action by the Minnesota Board of Dentistry.
115.16 (d) A provider who has been terminated or not designated may appeal only through
115.17 the contested hearing process as defined in section 14.02, subdivision 3, by filing with the
115.18 commissioner a written request of appeal. The appeal request must be received by the
115.19 commissioner no later than 30 days after notification of termination or nondesignation.
115.20 (e) The commissioner may make an exception to paragraph (a), clauses (1) and (3),
115.21 and paragraph (b), if an action taken by the Minnesota Board of Dentistry, commissioner
115.22 of human services, or contracted health plan is the result of a onetime event by an
115.23 individual employed or contracted by a group practice.

115.24 **EFFECTIVE DATE.** This section is effective the day following final enactment.

115.25 Sec. 42. Minnesota Statutes 2008, section 256D.03, subdivision 4, is amended to read:
115.26 Subd. 4. **General assistance medical care; services.** (a)(i) For a person who is
115.27 eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical
115.28 care covers, except as provided in paragraph (c):
115.29 (1) inpatient hospital services;
115.30 (2) outpatient hospital services;
115.31 (3) services provided by Medicare certified rehabilitation agencies;
115.32 (4) prescription drugs and other products recommended through the process
115.33 established in section 256B.0625, subdivision 13;
115.34 (5) equipment necessary to administer insulin and diagnostic supplies and equipment
115.35 for diabetics to monitor blood sugar level;

116.1 (6) eyeglasses and eye examinations provided by a physician or optometrist;
116.2 (7) hearing aids;
116.3 (8) prosthetic devices;
116.4 (9) laboratory and X-ray services;
116.5 (10) physician's services;
116.6 (11) medical transportation except special transportation;
116.7 (12) chiropractic services as covered under the medical assistance program;
116.8 (13) podiatric services;
116.9 (14) dental services as covered under the medical assistance program;
116.10 (15) mental health services covered under chapter 256B;
116.11 (16) prescribed medications for persons who have been diagnosed as mentally ill as
116.12 necessary to prevent more restrictive institutionalization;
116.13 (17) medical supplies and equipment, and Medicare premiums, coinsurance and
116.14 deductible payments;
116.15 (18) medical equipment not specifically listed in this paragraph when the use of
116.16 the equipment will prevent the need for costlier services that are reimbursable under
116.17 this subdivision;
116.18 (19) services performed by a certified pediatric nurse practitioner, a certified family
116.19 nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological
116.20 nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse
116.21 practitioner in independent practice, if (1) the service is otherwise covered under this
116.22 chapter as a physician service, (2) the service provided on an inpatient basis is not included
116.23 as part of the cost for inpatient services included in the operating payment rate, and (3) the
116.24 service is within the scope of practice of the nurse practitioner's license as a registered
116.25 nurse, as defined in section 148.171;
116.26 (20) services of a certified public health nurse or a registered nurse practicing in
116.27 a public health nursing clinic that is a department of, or that operates under the direct
116.28 authority of, a unit of government, if the service is within the scope of practice of the
116.29 public health nurse's license as a registered nurse, as defined in section 148.171;
116.30 (21) telemedicine consultations, to the extent they are covered under section
116.31 256B.0625, subdivision 3b;
116.32 (22) care coordination and patient education services provided by a community
116.33 health worker according to section 256B.0625, subdivision 49; and
116.34 (23) regardless of the number of employees that an enrolled health care provider
116.35 may have, sign language interpreter services when provided by an enrolled health care

117.1 provider during the course of providing a direct, person-to-person covered health care
117.2 service to an enrolled recipient who has a hearing loss and uses interpreting services.

117.3 (ii) Effective October 1, 2003, for a person who is eligible under subdivision 3,
117.4 paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited
117.5 to inpatient hospital services, including physician services provided during the inpatient
117.6 hospital stay. A $1,000 deductible is required for each inpatient hospitalization.

117.7 (b) Effective August 1, 2005, sex reassignment surgery is not covered under this
117.8 subdivision.

117.9 (c) In order to contain costs, the commissioner of human services shall select
117.10 vendors of medical care who can provide the most economical care consistent with high
117.11 medical standards and shall where possible contract with organizations on a prepaid
117.12 capitation basis to provide these services. The commissioner shall consider proposals by
117.13 counties and vendors for prepaid health plans, competitive bidding programs, block grants,
117.14 or other vendor payment mechanisms designed to provide services in an economical
117.15 manner or to control utilization, with safeguards to ensure that necessary services are
117.16 provided. Before implementing prepaid programs in counties with a county operated or
117.17 affiliated public teaching hospital or a hospital or clinic operated by the University of
117.18 Minnesota, the commissioner shall consider the risks the prepaid program creates for the
117.19 hospital and allow the county or hospital the opportunity to participate in the program in a
117.20 manner that reflects the risk of adverse selection and the nature of the patients served by
117.21 the hospital, provided the terms of participation in the program are competitive with the
117.22 terms of other participants considering the nature of the population served. Payment for
117.23 services provided pursuant to this subdivision shall be as provided to medical assistance
117.24 vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For
117.25 payments made during fiscal year 1990 and later years, the commissioner shall consult
117.26 with an independent actuary in establishing prepayment rates, but shall retain final control
117.27 over the rate methodology.

117.28 (d) Effective January 1, 2008, drug coverage under general assistance medical
117.29 care is limited to prescription drugs that:

117.30 (i) are covered under the medical assistance program as described in section
117.31 256B.0625, subdivisions 13 and 13d; and

117.32 (ii) are provided by manufacturers that have fully executed general assistance
117.33 medical care rebate agreements with the commissioner and comply with the agreements.
117.34 Prescription drug coverage under general assistance medical care must conform to
117.35 coverage under the medical assistance program according to section 256B.0625,
117.36 subdivisions 13 to 13g.

118.1 (e) Recipients eligible under subdivision 3, paragraph (a), shall pay the following
118.2 co-payments for services provided on or after October 1, 2003, and before January 1, 2009:
118.3 (1) $25 for eyeglasses;
118.4 (2) $25 for nonemergency visits to a hospital-based emergency room;
118.5 (3) $3 per brand-name drug prescription and $1 per generic drug prescription,
118.6 subject to a $12 per month maximum for prescription drug co-payments. No co-payments
118.7 shall apply to antipsychotic drugs when used for the treatment of mental illness; and
118.8 (4) 50 percent coinsurance on restorative dental services.
118.9 (f) Recipients eligible under subdivision 3, paragraph (a), shall include the following
118.10 co-payments for services provided on or after January 1, 2009:
118.11 (1) $25 for nonemergency visits to a hospital-based emergency room; and
118.12 (2) $3 per brand-name drug prescription and $1 per generic drug prescription,
118.13 subject to a $7 per month maximum for prescription drug co-payments. No co-payments
118.14 shall apply to antipsychotic drugs when used for the treatment of mental illness.
118.15 (g) MS 2007 Supp [Expired]
118.16 (h) Effective January 1, 2009, co-payments shall be limited to one per day per
118.17 provider for nonemergency visits to a hospital-based emergency room. Recipients of
118.18 general assistance medical care are responsible for all co-payments in this subdivision.
118.19 The general assistance medical care reimbursement to the provider shall be reduced by the
118.20 amount of the co-payment, except that reimbursement for prescription drugs shall not be
118.21 reduced once a recipient has reached the $7 per month maximum for prescription drug
118.22 co-payments. The provider collects the co-payment from the recipient. Providers may not
118.23 deny services to recipients who are unable to pay the co-payment.
118.24 (i) General assistance medical care reimbursement to fee-for-service providers
118.25 and payments to managed care plans shall not be increased as a result of the removal of
118.26 the co-payments effective January 1, 2009.
118.27 (j) Any county may, from its own resources, provide medical payments for which
118.28 state payments are not made.
118.29 (k) Chemical dependency services that are reimbursed under chapter 254B must not
118.30 be reimbursed under general assistance medical care.
118.31 (l) The maximum payment for new vendors enrolled in the general assistance
118.32 medical care program after the base year shall be determined from the average usual and
118.33 customary charge of the same vendor type enrolled in the base year.
118.34 (m) The conditions of payment for services under this subdivision are the same
118.35 as the conditions specified in rules adopted under chapter 256B governing the medical
118.36 assistance program, unless otherwise provided by statute or rule.

119.1 (n) Inpatient and outpatient payments shall be reduced by five percent, effective July
119.2 1, 2003. This reduction is in addition to the five percent reduction effective July 1, 2003,
119.3 and incorporated by reference in paragraph (l).
119.4 (o) Payments for all other health services except inpatient, outpatient, and pharmacy
119.5 services shall be reduced by five percent, effective July 1, 2003.
119.6 (p) Payments to managed care plans shall be reduced by five percent for services
119.7 provided on or after October 1, 2003.
119.8 (q) A hospital receiving a reduced payment as a result of this section may apply the
119.9 unpaid balance toward satisfaction of the hospital's bad debts.
119.10 (r) Fee-for-service payments for nonpreventive visits shall be reduced by $3 for
119.11 services provided on or after January 1, 2006. For purposes of this subdivision, a visit
119.12 means an episode of service which is required because of a recipient's symptoms,
119.13 diagnosis, or established illness, and which is delivered in an ambulatory setting by
119.14 a physician or physician ancillary, chiropractor, podiatrist, advance practice nurse,
119.15 audiologist, optician, or optometrist.
119.16 (s) Payments to managed care plans shall not be increased as a result of the removal
119.17 of the $3 nonpreventive visit co-payment effective January 1, 2006.
119.18 (t) Payments for mental health services added as covered benefits after December
119.19 31, 2007, are not subject to the reductions in paragraphs (l), (n), (o), and (p).
119.20 (u) In addition to the reductions in paragraphs (k) and (l), effective service date
119.21 July 1, 2009, total payments for basic care services, except prescription drugs, medical
119.22 supplies, prosthetics, lab, radiology, medical transportation, and services subject to or
119.23 specifically exempted from paragraph (v), shall be reduced by 3.0 percent, prior to
119.24 third-party liability. Payments made to managed care and county-based purchasing plans
119.25 shall be reduced for services provided on or after January 1, 2010, to reflect this reduction.
119.26 (v) Effective for services rendered on or after July 1, 2009, payment rates for
119.27 physician and professional services shall be reduced by three percent over the rates in
119.28 effect on June 30, 2009, except for office or other outpatient services (procedure codes
119.29 99201 to 99215) and preventive medicine services (procedure codes 99381 to 99412)
119.30 billed by the following primary care specialties: general practitioner, internal medicine,
119.31 pediatrics, geriatric nurse practitioner, pediatric nurse practitioner, family practice nurse
119.32 practitioner, adult nurse practitioner, geriatrics, and family practice. The commissioner,
119.33 effective January 1, 2010, shall reduce capitation rates paid to managed care and
119.34 county-based purchasing plans under paragraph (c) to reflect this payment reduction.

120.1 Sec. 43. Minnesota Statutes 2008, section 256L.04, subdivision 10a, is amended to
120.2 read:

120.3 Subd. 10a. **Sponsor's income and resources deemed available; documentation.**
120.4 When determining eligibility for any federal or state benefits under sections 256L.01 to
120.5 256L.18, the income and resources of all noncitizens whose sponsor signed an affidavit of
120.6 support as defined under United States Code, title 8, section 1183a, shall be deemed to
120.7 include their sponsors' income and resources as defined in the Personal Responsibility
120.8 and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections
120.9 421 and 422, and subsequently set out in federal rules. To be eligible for the program,
120.10 noncitizens must provide documentation of their immigration status. Beginning July
120.11 1, 2010, or upon federal approval, whichever is later, sponsor deeming does not apply
120.12 to pregnant women and children who are qualified noncitizens, as described in section
120.13 256B.06, subdivision 4, paragraph (b).

120.14 **EFFECTIVE DATE.** This section is effective July 1, 2010, or upon federal
120.15 approval, whichever is later. The commissioner shall notify the revisor of statutes when
120.16 federal approval has been obtained.

120.17 Sec. 44. Minnesota Statutes 2008, section 256L.04, is amended by adding a subdivision
120.18 to read:

120.19 Subd. 14. **Presumptive eligibility.** MinnesotaCare is available during a presumptive
120.20 period of eligibility, for children who appear to meet the income requirements of
120.21 subdivision 1, on the basis of preliminary information. The presumptive period begins
120.22 on the first day of the month following the date on which presumptive eligibility is
120.23 determined by the state or local agency. The agency must provide notice of presumptive
120.24 eligibility and information on the procedures for completing the eligibility process. The
120.25 effective date of coverage for children who are determined presumptively eligible is in
120.26 accordance with section 256L.05, subdivision 3. The presumptive period ends on the
120.27 earlier of the date of the determination for MinnesotaCare eligibility, or the last day of
120.28 the month following the month the presumptive eligibility period begins if a complete
120.29 application with requested verifications is not submitted by that date. Applicants and
120.30 enrollees who are denied or terminated for failure to complete an application or provide
120.31 verifications cannot be granted presumptive eligibility again for 12 months.

120.32 **EFFECTIVE DATE.** This section is effective July 1, 2011, or upon federal
120.33 approval, whichever is later.

121.1 Sec. 45. Minnesota Statutes 2008, section 256L.05, subdivision 1, is amended to read:

121.2 Subdivision 1. **Application assistance and information availability.** (a)
121.3 Applications and application assistance must be made available at provider offices, local
121.4 human services agencies, school districts, public and private elementary schools in which
121.5 25 percent or more of the students receive free or reduced price lunches, community health
121.6 offices, Women, Infants and Children (WIC) program sites, Head Start program sites,
121.7 public housing councils, crisis nurseries, child care centers, early childhood education
121.8 and preschool program sites, legal aid offices, and libraries. These sites may accept
121.9 applications and forward the forms to the commissioner or local county human services
121.10 agencies ~~that choose to participate as an enrollment site~~. Otherwise, applicants may apply
121.11 directly to the commissioner or to participating local county human services agencies.

121.12 (b) Application assistance must be available for applicants choosing to file an
121.13 online application.

121.14 (c) The commissioner and local agencies shall assist enrollees in choosing a
121.15 managed care organization by:

121.16 (1) establishing a Web site to provide information about managed care organizations
121.17 and to allow online enrollment;

121.18 (2) making applications and information on managed care organizations available
121.19 to applicants and enrollees according to Title VI of the Civil Rights Act and federal
121.20 regulations adopted under that law, or any guidance from the United States Department of
121.21 Health and Human Services; and

121.22 (3) making benefit educators available to assist applicants in choosing a managed
121.23 care organization.

121.24 Sec. 46. Minnesota Statutes 2008, section 256L.05, is amended by adding a subdivision
121.25 to read:

121.26 Subd. 1c. **Open enrollment and streamlined application and enrollment**
121.27 **process.** (a) The commissioner and local agencies working in partnership must develop a
121.28 streamlined and efficient application and enrollment process for medical assistance and
121.29 MinnesotaCare enrollees that meets the criteria specified in this subdivision.

121.30 (b) The commissioners of human services and education shall provide
121.31 recommendations to the legislature by January 15, 2010, on the creation of an open
121.32 enrollment process for medical assistance and MinnesotaCare that is coordinated with
121.33 the public education system. The recommendations must:

121.34 (1) be developed in consultation with medical assistance and MinnesotaCare
121.35 enrollees and representatives from organizations that advocate on behalf of children and

122.1 families, low-income persons and minority populations, counties, school administrators
122.2 and nurses, health plans, and health care providers;
122.3 (2) be based on enrollment and renewal procedures best practices, including express
122.4 lane eligibility as required under subdivision 1d;
122.5 (3) simplify the enrollment and renewal processes wherever possible; and
122.6 (4) establish a process:
122.7 (i) to disseminate information on medical assistance and MinnesotaCare to all
122.8 children in the public education system, including prekindergarten programs; and
122.9 (ii) for the commissioner of human services to enroll children and other household
122.10 members who are eligible.
122.11 The commissioner of human services in coordination with the commissioner of
122.12 education shall implement an open enrollment process by August 1, 2010, to be effective
122.13 beginning with the 2010-2011 school year.
122.14 (c) The commissioner and local agencies shall develop an online application process
122.15 for medical assistance and MinnesotaCare.
122.16 (d) The commissioner shall develop an application that is easily understandable
122.17 and does not exceed four pages in length.
122.18 (e) The commissioner of human services shall present to the legislature, by January
122.19 15, 2010, an implementation plan for the open enrollment period and online application
122.20 process.

122.21 **EFFECTIVE DATE.** This section is effective July 1, 2010, or upon federal
122.22 approval, which must be requested by the commissioner, whichever is later.

122.23 Sec. 47. Minnesota Statutes 2008, section 256L.05, is amended by adding a subdivision
122.24 to read:
122.25 Subd. 1d. **Express lane eligibility.** (a) Children who complete an application
122.26 for educational benefits and indicate an interest in enrolling in medical assistance or
122.27 MinnesotaCare on the application form shall have the form considered an application
122.28 for those programs.
122.29 (b) The commissioner of education shall forward electronically the information for
122.30 families who are eligible for educational benefits to the commissioner of human services
122.31 as required under section 124D.1115.
122.32 (c) The commissioner of human services shall accept the income determination
122.33 made by the commissioner of education in administering the free and reduced-price school
122.34 lunch program as proof of income for medical assistance and MinnesotaCare eligibility

123.1 until renewal. Within 30 days of receipt of information provided by the commissioner of
123.2 education under paragraph (d), the commissioner of human services shall:
123.3 (1) enroll all eligible children in the medical assistance or MinnesotaCare programs;
123.4 and
123.5 (2) provide information about medical assistance and MinnesotaCare to other
123.6 household members. The date of application for the medical assistance and MinnesotaCare
123.7 programs is the date on the signed application for educational benefits.

123.8 **EFFECTIVE DATE.** This section is effective July 1, 2011, or upon federal
123.9 approval, whichever is later.

123.10 Sec. 48. Minnesota Statutes 2008, section 256L.11, subdivision 1, is amended to read:
123.11 Subdivision 1. **Medical assistance rate to be used.** (a) Payment to providers under
123.12 sections 256L.01 to 256L.11 shall be at the same rates and conditions established for
123.13 medical assistance, except as provided in subdivisions 2 to 6.
123.14 (b) Effective service date July 1, 2009, total payments for basic care services, except
123.15 prescription drugs, medical supplies, prosthetics, lab, radiology, medical transportation,
123.16 and services subject to or specifically exempted from paragraph (c), shall be reduced
123.17 by 3.0 percent, prior to third-party liability. Payments made to managed care and
123.18 county-based purchasing plans shall be reduced for services provided on or after January
123.19 1, 2010, to reflect this reduction.
123.20 (c) Effective for services rendered on or after July 1, 2009, payment rates for
123.21 physician and professional services shall be reduced by three percent over the rates in
123.22 effect on June 30, 2009, except for office or other outpatient services (procedure codes
123.23 99201 to 99215) and preventive medicine services (procedure codes 99381 to 99412)
123.24 billed by the following primary care specialties: general practitioner, internal medicine,
123.25 pediatrics, geriatric nurse practitioner, pediatric nurse practitioner, family practice nurse
123.26 practitioner, adult nurse practitioner, geriatrics, and family practice. The commissioner,
123.27 effective January 1, 2010, shall reduce capitation rates paid to managed care and
123.28 county-based purchasing plans under section 256L.12 to reflect this payment reduction.

123.29 Sec. 49. Minnesota Statutes 2008, section 256L.11, subdivision 7, is amended to read:
123.30 Subd. 7. **Critical access dental providers.** Effective for dental services provided
123.31 to MinnesotaCare enrollees on or after January 1, ~~2007~~ 2010, the commissioner shall
123.32 increase payment rates to dentists and dental clinics deemed by the commissioner to be
123.33 critical access providers under section 256B.76, ~~subdivision 4~~ subdivisions 4 and 4a, by
123.34 ~~50~~ 30 percent above the payment rate that would otherwise be paid to the provider. The

124.1 commissioner shall pay the prepaid health plans under contract with the commissioner
124.2 amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate
124.3 increase to providers who have been identified by the commissioner as critical access
124.4 dental providers under section 256B.76, subdivision 4. The commissioner shall administer
124.5 this subdivision within the limits of available appropriations.

124.6 Sec. 50. Minnesota Statutes 2008, section 256L.12, subdivision 9, is amended to read:
124.7 Subd. 9. **Rate setting; performance withholds.** (a) Rates will be prospective,
124.8 per capita, where possible. The commissioner may allow health plans to arrange for
124.9 inpatient hospital services on a risk or nonrisk basis. The commissioner shall consult with
124.10 an independent actuary to determine appropriate rates.
124.11 ~~(b) For services rendered on or after January 1, 2003, to December 31, 2003, the~~
124.12 ~~commissioner shall withhold .5 percent of managed care plan payments under this section~~
124.13 ~~pending completion of performance targets. The withheld funds must be returned no~~
124.14 ~~sooner than July 1 and no later than July 31 of the following year if performance targets~~
124.15 ~~in the contract are achieved. A managed care plan may include as admitted assets under~~
124.16 ~~section 62D.044 any amount withheld under this paragraph that is reasonably expected~~
124.17 ~~to be returned.~~
124.18 ~~(c)~~ (b) For services rendered on or after January 1, 2004, the commissioner shall
124.19 withhold five percent of managed care plan payments and county-based purchasing
124.20 plan payments under this section pending completion of performance targets. Each
124.21 performance target must be quantifiable, objective, measurable, and reasonably attainable,
124.22 except in the case of a performance target based on a federal or state law or rule. Criteria
124.23 for assessment of each performance target must be outlined in writing prior to the
124.24 contract effective date. The managed care plan must demonstrate, to the commissioner's
124.25 satisfaction, that the data submitted regarding attainment of the performance target is
124.26 accurate. The commissioner shall periodically change the administrative measures used
124.27 as performance targets in order to improve plan performance across a broader range of
124.28 administrative services. The performance targets must include measurement of plan
124.29 efforts to contain spending on health care services and administrative activities. The
124.30 commissioner may adopt plan-specific performance targets that take into account factors
124.31 affecting only one plan, such as characteristics of the plan's enrollee population. The
124.32 withheld funds must be returned no sooner than July 1 and no later than July 31 of the
124.33 following calendar year if performance targets in the contract are achieved. ~~A managed~~
124.34 ~~care plan or a county-based purchasing plan under section 256B.692 may include as~~

125.1 ~~admitted assets under section 62D.044 any amount withheld under this paragraph that is~~
125.2 ~~reasonably expected to be returned.~~
125.3 (c) Effective for services rendered on or after January 1, 2010, the commissioner
125.4 shall include as part of the performance targets described in paragraph (b) a reduction in
125.5 the plan's emergency room utilization rate for state health care program enrollees by a
125.6 measurable rate of five percent from the plan's utilization rate for the previous calendar
125.7 year.
125.8 The withheld funds must be returned no sooner than July 1 and no later than July
125.9 31 of the following calendar year if the managed care plan or county-based purchasing
125.10 plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization
125.11 rate was achieved.
125.12 The withhold described in this paragraph shall continue for each consecutive
125.13 contract period until the health plan's emergency room utilization rate for state health care
125.14 program enrollees is reduced by 25 percent of the health plan's emergency room utilization
125.15 rate for state health care program enrollees for calendar year 2008.
125.16 (d) A managed care plan or a county-based purchasing plan under section 256B.692
125.17 may include as admitted assets under section 62D.044 any amount withheld under this
125.18 section that is reasonably expected to be returned.

125.19 Sec. 51. Minnesota Statutes 2008, section 256L.17, subdivision 3, is amended to read:
125.20 Subd. 3. **Documentation.** (a) The commissioner of human services shall require
125.21 individuals and families, at the time of application or renewal, to indicate on a ~~checkoff~~
125.22 form developed by the commissioner whether they satisfy the MinnesotaCare asset
125.23 requirement.
125.24 (b) The commissioner may require individuals and families to provide any
125.25 information the commissioner determines necessary to verify compliance with the asset
125.26 requirement, if the commissioner determines that there is reason to believe that an
125.27 individual or family has assets that exceed the program limit.

125.28 Sec. 52. Minnesota Statutes 2008, section 501B.89, is amended by adding a
125.29 subdivision to read:
125.30 Subd. 4. **Annual filing requirement for supplemental needs trusts.** (a) A trustee
125.31 of a trust under subdivision 3 and United States Code, title 42, section 1396p(d)(4)(A) or
125.32 (C), shall submit to the commissioner of human services, at the time of a beneficiary's
125.33 request for medical assistance, the following information about the trust:
125.34 (1) a copy of the trust instrument; and

126.1 (2) an inventory of the beneficiary's trust account assets and the value of those assets.
126.2 (b) A trustee of a trust under subdivision 3 and United States Code, title 42, section
126.3 1396p(d)(4)(A) or (C), shall submit an accounting of the beneficiary's trust account to the
126.4 commissioner of human services at least annually until the trust, or the beneficiary's
126.5 interest in the trust, terminates. Accountings are due on the anniversary of the execution
126.6 date of the trust unless another annual date is established by the terms of the trust. The
126.7 accounting must include the following information for the accounting period:
126.8 (1) an inventory of trust assets and the value of those assets at the beginning of the
126.9 accounting period;
126.10 (2) additions to the trust during the accounting period and the source of those
126.11 additions;
126.12 (3) itemized distributions from the trust during the accounting period, including the
126.13 purpose of the distributions and to whom the distributions were made;
126.14 (4) an inventory of trust assets and the value of those assets at the end of the
126.15 accounting period; and
126.16 (5) changes to the trust instrument during the accounting period.
126.17 (c) For the purpose of paragraph (b), an accounting period is 12 months unless an
126.18 accounting period of a different length is permitted by the commissioner.

126.19 **EFFECTIVE DATE.** This section is effective for applications for medical
126.20 assistance and renewals of medical assistance submitted on or after July 1, 2009.

126.21 Sec. 53. Minnesota Statutes 2008, section 519.05, is amended to read:

126.22 **519.05 LIABILITY OF HUSBAND AND WIFE.**

126.23 (a) A spouse is not liable to a creditor for any debts of the other spouse. Where
126.24 husband and wife are living together, they shall be jointly and severally liable for
126.25 necessary medical services that have been furnished to either spouse, including any claims
126.26 arising under section 246.53, 256B.15, 256D.16, or 261.04, and necessary household
126.27 articles and supplies furnished to and used by the family. Notwithstanding this paragraph,
126.28 in a proceeding under chapter 518 the court may apportion such debt between the spouses.
126.29 (b) Either spouse may close a credit card account or other unsecured consumer line
126.30 of credit on which both spouses are contractually liable, by giving written notice to the
126.31 creditor.

126.32 Sec. 54. Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision
126.33 1, as amended by Laws 2004, chapter 272, article 2, section 2, is amended to read:

127.1 Subdivision 1. **Total Appropriation** **$ 3,848,049,000 $ 4,135,780,000**

127.2 Summary by Fund

127.3 General	3,301,811,000	3,561,055,000
127.4 State Government 127.5 Special Revenue	534,000	534,000
127.6 Health Care Access	273,723,000	302,272,000
127.7 Federal TANF	270,425,000	270,363,000
127.8 Lottery Cash Flow	1,556,000	1,556,000

127.9 **Federal Contingency Appropriation.** (a)
127.10 Federal Medicaid funds made available
127.11 under title IV of the federal Jobs and Growth
127.12 Tax Relief Reconciliation Act of 2003
127.13 are appropriated to the commissioner of
127.14 human services for use in the state's medical
127.15 assistance and MinnesotaCare programs.
127.16 The commissioners of human services and
127.17 finance shall report to the legislative advisory
127.18 committee on the additional federal Medicaid
127.19 matching funds that will be available to the
127.20 state.

127.21 (b) Because of the availability of these funds,
127.22 the following policies shall become effective:

127.23 (1) medical assistance and MinnesotaCare
127.24 eligibility and local financial participation
127.25 changes provided for in this act may be
127.26 implemented prior to September 2, 2003, or
127.27 may be delayed as necessary to maximize
127.28 the use of federal funds received under
127.29 title IV of the Jobs and Growth Tax Relief
127.30 Reconciliation Act of 2003;

127.31 (2) the aggregate cap on the services
127.32 identified in Minnesota Statutes, section
127.33 256L.035, paragraph (a), clause (3), shall
127.34 be increased from $2,000 to $5,000. This
127.35 increase shall expire at the end of fiscal year
127.36 2007. Funds may be transferred from the

128.1 general fund to the health care access fund as
128.2 necessary to implement this provision; and

128.3 (3) the following payment shifts shall not be
128.4 implemented:

128.5 (i) MFIP payment shift found in subdivision
128.6 11;

128.7 (ii) the county payment shift found in
128.8 subdivision 1; and

128.9 (iii) the delay in medical assistance
128.10 and general assistance medical care
128.11 fee-for-service payments found in
128.12 subdivision 6.

128.13 (c) Notwithstanding section 14, paragraphs
128.14 (a) and (b) shall expire June 30, 2007.

128.15 **Receipts for Systems Projects.**
128.16 Appropriations and federal receipts for
128.17 information system projects for MAXIS,
128.18 PRISM, MMIS, and SSIS must be deposited
128.19 in the state system account authorized in
128.20 Minnesota Statutes, section 256.014. Money
128.21 appropriated for computer projects approved
128.22 by the Minnesota office of technology,
128.23 funded by the legislature, and approved
128.24 by the commissioner of finance may be
128.25 transferred from one project to another
128.26 and from development to operations as the
128.27 commissioner of human services considers
128.28 necessary. Any unexpended balance in
128.29 the appropriation for these projects does
128.30 not cancel but is available for ongoing
128.31 development and operations.

128.32 **Gifts.** Notwithstanding Minnesota Statutes,
128.33 chapter 7, the commissioner may accept
128.34 on behalf of the state additional funding

129.1 from sources other than state funds for the
129.2 purpose of financing the cost of assistance
129.3 program grants or nongrant administration.
129.4 All additional funding is appropriated to the
129.5 commissioner for use as designated by the
129.6 grantor of funding.

129.7 **Systems Continuity.** In the event of
129.8 disruption of technical systems or computer
129.9 operations, the commissioner may use
129.10 available grant appropriations to ensure
129.11 continuity of payments for maintaining the
129.12 health, safety, and well-being of clients
129.13 served by programs administered by the
129.14 department of human services. Grant funds
129.15 must be used in a manner consistent with the
129.16 original intent of the appropriation.

129.17 **Nonfederal Share Transfers.** The
129.18 nonfederal share of activities for which
129.19 federal administrative reimbursement is
129.20 appropriated to the commissioner may be
129.21 transferred to the special revenue fund.

129.22 **TANF Funds Appropriated to Other**
129.23 **Entities.** Any expenditures from the TANF
129.24 block grant shall be expended in accordance
129.25 with the requirements and limitations of part
129.26 A of title IV of the Social Security Act, as
129.27 amended, and any other applicable federal
129.28 requirement or limitation. Prior to any
129.29 expenditure of these funds, the commissioner
129.30 shall assure that funds are expended in
129.31 compliance with the requirements and
129.32 limitations of federal law and that any
129.33 reporting requirements of federal law are
129.34 met. It shall be the responsibility of any entity
129.35 to which these funds are appropriated to

130.1 implement a memorandum of understanding
130.2 with the commissioner that provides the
130.3 necessary assurance of compliance prior to
130.4 any expenditure of funds. The commissioner
130.5 shall receipt TANF funds appropriated
130.6 to other state agencies and coordinate all
130.7 related interagency accounting transactions
130.8 necessary to implement these appropriations.
130.9 Unexpended TANF funds appropriated to
130.10 any state, local, or nonprofit entity cancel
130.11 at the end of the state fiscal year unless
130.12 appropriating language permits otherwise.

130.13 **TANF Funds Transferred to Other Federal**
130.14 **Grants.** The commissioner must authorize
130.15 transfers from TANF to other federal block
130.16 grants so that funds are available to meet the
130.17 annual expenditure needs as appropriated.
130.18 Transfers may be authorized prior to the
130.19 expenditure year with the agreement of the
130.20 receiving entity. Transferred funds must be
130.21 expended in the year for which the funds
130.22 were appropriated unless appropriation
130.23 language permits otherwise. In accelerating
130.24 transfer authorizations, the commissioner
130.25 must aim to preserve the future potential
130.26 transfer capacity from TANF to other block
130.27 grants.

130.28 **TANF Maintenance of Effort.** (a) In
130.29 order to meet the basic maintenance of
130.30 effort (MOE) requirements of the TANF
130.31 block grant specified under Code of Federal
130.32 Regulations, title 45, section 263.1, the
130.33 commissioner may only report nonfederal
130.34 money expended for allowable activities
130.35 listed in the following clauses as TANF/MOE
130.36 expenditures:

131.1 (1) MFIP cash, diversionary work program,
131.2 and food assistance benefits under Minnesota
131.3 Statutes, chapter 256J;

131.4 (2) the child care assistance programs
131.5 under Minnesota Statutes, sections 119B.03
131.6 and 119B.05, and county child care
131.7 administrative costs under Minnesota
131.8 Statutes, section 119B.15;

131.9 (3) state and county MFIP administrative
131.10 costs under Minnesota Statutes, chapters
131.11 256J and 256K;

131.12 (4) state, county, and tribal MFIP
131.13 employment services under Minnesota
131.14 Statutes, chapters 256J and 256K;

131.15 (5) expenditures made on behalf of
131.16 noncitizen MFIP recipients who qualify
131.17 for the medical assistance without federal
131.18 financial participation program under
131.19 Minnesota Statutes, section 256B.06,
131.20 subdivision 4, paragraphs (d), (e), and (j);
131.21 and

131.22 (6) qualifying working family credit
131.23 expenditures under Minnesota Statutes,
131.24 section 290.0671.

131.25 (b) The commissioner shall ensure that
131.26 sufficient qualified nonfederal expenditures
131.27 are made each year to meet the state's
131.28 TANF/MOE requirements. For the activities
131.29 listed in paragraph (a), clauses (2) to
131.30 (6), the commissioner may only report
131.31 expenditures that are excluded from the
131.32 definition of assistance under Code of
131.33 Federal Regulations, title 45, section 260.31.

132.1 (c) By August 31 of each year, the
132.2 commissioner shall make a preliminary
132.3 calculation to determine the likelihood
132.4 that the state will meet its annual federal
132.5 work participation requirement under Code
132.6 of Federal Regulations, title 45, sections
132.7 261.21 and 261.23, after adjustment for any
132.8 caseload reduction credit under Code of
132.9 Federal Regulations, title 45, section 261.41.
132.10 If the commissioner determines that the
132.11 state will meet its federal work participation
132.12 rate for the federal fiscal year ending that
132.13 September, the commissioner may reduce the
132.14 expenditure under paragraph (a), clause (1),
132.15 to the extent allowed under Code of Federal
132.16 Regulations, title 45, section 263.1(a)(2).

132.17 (d) For fiscal years beginning with state
132.18 fiscal year 2003, the commissioner shall
132.19 assure that the maintenance of effort used
132.20 by the commissioner of finance for the
132.21 February and November forecasts required
132.22 under Minnesota Statutes, section 16A.103,
132.23 contains expenditures under paragraph (a),
132.24 clause (1), equal to at least 25 percent of
132.25 the total required under Code of Federal
132.26 Regulations, title 45, section 263.1.

132.27 (e) If nonfederal expenditures for the
132.28 programs and purposes listed in paragraph
132.29 (a) are insufficient to meet the state's
132.30 TANF/MOE requirements, the commissioner
132.31 shall recommend additional allowable
132.32 sources of nonfederal expenditures to the
132.33 legislature, if the legislature is or will be in
132.34 session to take action to specify additional
132.35 sources of nonfederal expenditures for
132.36 TANF/MOE before a federal penalty is

133.1 imposed. The commissioner shall otherwise
133.2 provide notice to the legislative commission
133.3 on planning and fiscal policy under paragraph
133.4 (g).

133.5 (f) If the commissioner uses authority
133.6 granted under section 11, or similar authority
133.7 granted by a subsequent legislature, to
133.8 meet the state's TANF/MOE requirement
133.9 in a reporting period, the commissioner
133.10 shall inform the chairs of the appropriate
133.11 legislative committees about all transfers
133.12 made under that authority for this purpose.

133.13 (g) If the commissioner determines that
133.14 nonfederal expenditures under paragraph
133.15 (a) are insufficient to meet TANF/MOE
133.16 expenditure requirements, and if the
133.17 legislature is not or will not be in
133.18 session to take timely action to avoid a
133.19 federal penalty, the commissioner may
133.20 report nonfederal expenditures from
133.21 other allowable sources as TANF/MOE
133.22 expenditures after the requirements of this
133.23 paragraph are met. The commissioner
133.24 may report nonfederal expenditures
133.25 in addition to those specified under
133.26 paragraph (a) as nonfederal TANF/MOE
133.27 expenditures, but only ten days after the
133.28 commissioner of finance has first submitted
133.29 the commissioner's recommendations for
133.30 additional allowable sources of nonfederal
133.31 TANF/MOE expenditures to the members of
133.32 the legislative commission on planning and
133.33 fiscal policy for their review.

133.34 (h) The commissioner of finance shall not
133.35 incorporate any changes in federal TANF

134.1 expenditures or nonfederal expenditures for
134.2 TANF/MOE that may result from reporting
134.3 additional allowable sources of nonfederal
134.4 TANF/MOE expenditures under the interim
134.5 procedures in paragraph (g) into the February
134.6 or November forecasts required under
134.7 Minnesota Statutes, section 16A.103, unless
134.8 the commissioner of finance has approved
134.9 the additional sources of expenditures under
134.10 paragraph (g).

134.11 (i) Minnesota Statutes, section 256.011,
134.12 subdivision 3, which requires that federal
134.13 grants or aids secured or obtained under that
134.14 subdivision be used to reduce any direct
134.15 appropriations provided by law, do not apply
134.16 if the grants or aids are federal TANF funds.

134.17 (j) Notwithstanding section 14, paragraph
134.18 (a), clauses (1) to (6), and paragraphs (b) to
134.19 (j) expire June 30, 2007.

134.20 **Working Family Credit Expenditures as**
134.21 **TANF MOE.** The commissioner may claim
134.22 as TANF maintenance of effort up to the
134.23 following amounts of working family credit
134.24 expenditures for the following fiscal years:

134.25 (1) fiscal year 2004, $7,013,000;

134.26 (2) fiscal year 2005, $25,133,000;

134.27 (3) fiscal year 2006, $6,942,000; and

134.28 (4) fiscal year 2007, $6,707,000.

134.29 **Fiscal Year 2003 Appropriations**
134.30 **Carryforward.** Effective the day following
134.31 final enactment, notwithstanding Minnesota
134.32 Statutes, section 16A.28, or any other law to
134.33 the contrary, state agencies and constitutional
134.34 offices may carry forward unexpended

135.1 and unencumbered nongrant operating
135.2 balances from fiscal year 2003 general fund
135.3 appropriations into fiscal year 2004 to offset
135.4 general budget reductions.

135.5 **Transfer of Grant Balances.** Effective
135.6 the day following final enactment, the
135.7 commissioner of human services, with
135.8 the approval of the commissioner of
135.9 finance and after notification of the chair
135.10 of the senate health, human services and
135.11 corrections budget division and the chair
135.12 of the house of representatives health
135.13 and human services finance committee,
135.14 may transfer unencumbered appropriation
135.15 balances for the biennium ending June 30,
135.16 2003, in fiscal year 2003 among the MFIP,
135.17 MFIP child care assistance under Minnesota
135.18 Statutes, section 119B.05, general assistance,
135.19 general assistance medical care, medical
135.20 assistance, Minnesota supplemental aid,
135.21 and group residential housing programs,
135.22 and the entitlement portion of the chemical
135.23 dependency consolidated treatment fund, and
135.24 between fiscal years of the biennium.

135.25 **TANF Appropriation Cancellation.**
135.26 Notwithstanding the provisions of Laws
135.27 2000, chapter 488, article 1, section 16,
135.28 any prior appropriations of TANF funds
135.29 to the department of trade and economic
135.30 development or to the job skills partnership
135.31 board or any transfers of TANF funds from
135.32 another agency to the department of trade
135.33 and economic development or to the job
135.34 skills partnership board are not available
135.35 until expended, and if unobligated as of June

30, 2003, these appropriations or transfers shall cancel to the TANF fund.

Shift County Payment. The commissioner shall make up to 100 percent of the calendar year 2005 payments to counties for developmental disabilities semi-independent living services grants, developmental disabilities family support grants, and adult mental health grants from fiscal year 2006 appropriations. This is a onetime payment shift. Calendar year 2006 and future payments for these grants are not affected by this shift. This provision expires June 30, 2006.

Capitation Rate Increase. Of the health care access fund appropriations to the University of Minnesota in the higher education omnibus appropriation bill, ~~$2,157,000 in fiscal year 2004 and $2,157,000 in fiscal year 2005 are to be used to increase the capitation payments under~~ for fiscal years beginning July 1, 2003, and thereafter, $2,157,000 each year shall be transferred to the commissioner for purposes of Minnesota Statutes, section 256B.69. Notwithstanding the provisions of section 14, this provision shall not expire.

Sec. 55. **INCOME METHODOLOGY.**

The commissioner of human services shall study approaches toward adopting a uniform income methodology for families and children under medical assistance and MinnesotaCare. The approaches to be examined by the commissioner must include, but are not limited to: (1) replacing the MinnesotaCare gross income standard with a net income standard based on the medical assistance families with children methodology; and (2) replacing the medical assistance net income standard for families with children with the MinnesotaCare gross income standard. The commissioner must evaluate the impact of each approach on the number of potential MinnesotaCare and medical assistance enrolles

137.1 who are families and children and on administrative, health care, and other costs to the
137.2 state. The commissioner shall present findings and recommendations to the legislative
137.3 committees with jurisdiction over health care by January 15, 2010.

137.4 Sec. 56. **ADMINISTRATION OF MINNESOTACARE.**

137.5 The commissioner of human services, in cooperation with representatives of
137.6 county human services agencies, shall develop a plan to administer the MinnesotaCare
137.7 program. The plan must require county agencies to administer MinnesotaCare in their
137.8 respective counties under the supervision of the state agency and the commissioner
137.9 of human services. The plan, to the extent feasible, must incorporate procedures and
137.10 requirements that are identical to or consistent with those procedures and requirements
137.11 that apply to county administration of the medical assistance program. The commissioner
137.12 shall present recommendations to the legislative committees with jurisdiction over health
137.13 care by January 15, 2010.

137.14 Sec. 57. **FEDERAL APPROVAL.**

137.15 The commissioner of human services shall resubmit for federal approval the
137.16 elimination of depreciation for self-employed farmers in determining income eligibility
137.17 for MinnesotaCare passed in Laws 2007, chapter 147, article 5, section 33.

137.18 Sec. 58. **REPEALER.**

137.19 Minnesota Statutes 2008, section 256.962, subdivision 7, is repealed.

137.20 **ARTICLE 7**

137.21 **TECHNICAL**

137.22 Section 1. Minnesota Statutes 2008, section 125A.744, subdivision 3, is amended to
137.23 read:

137.24 Subd. 3. **Implementation.** Consistent with section 256B.0625, subdivision 26,
137.25 school districts may enroll as medical assistance providers or subcontractors and bill
137.26 the Department of Human Services under the medical assistance fee for service claims
137.27 processing system for special education services which are covered services under chapter
137.28 256B, which are provided in the school setting for a medical assistance recipient, and for
137.29 whom the district has secured informed consent consistent with section 13.05, subdivision
137.30 4, paragraph (d), and section 256B.77, subdivision 2, paragraph (p), to bill for each type
137.31 of covered service. School districts shall be reimbursed by the commissioner of human
137.32 services for the federal share of individual education plan health-related services that

qualify for reimbursement by medical assistance, minus up to five percent retained by the commissioner of human services for administrative costs, not to exceed $350,000 per fiscal year. The commissioner may withhold up to five percent of each payment to a school district. Following the end of each fiscal year, the commissioner shall settle up with each school district in order to ensure that collections from each district for departmental administrative costs are made on a pro rata basis according to federal earnings for these services in each district. A school district is not eligible to enroll as a home care provider or a personal care provider organization for purposes of billing home care services under sections 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659 until the commissioner of human services issues a bulletin instructing county public health nurses on how to assess for the needs of eligible recipients during school hours. To use private duty nursing services or personal care services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school.

Sec. 2. Minnesota Statutes 2008, section 144A.46, subdivision 1, is amended to read:

Subdivision 1. **License required.** (a) A home care provider may not operate in the state without a current license issued by the commissioner of health. A home care provider may hold a separate license for each class of home care licensure.

(b) Within ten days after receiving an application for a license, the commissioner shall acknowledge receipt of the application in writing. The acknowledgment must indicate whether the application appears to be complete or whether additional information is required before the application will be considered complete. Within 90 days after receiving a complete application, the commissioner shall either grant or deny the license. If an applicant is not granted or denied a license within 90 days after submitting a complete application, the license must be deemed granted. An applicant whose license has been deemed granted must provide written notice to the commissioner before providing a home care service.

(c) Each application for a home care provider license, or for a renewal of a license, shall be accompanied by a fee to be set by the commissioner under section 144.122.

(d) The commissioner of health, in consultation with the commissioner of human services, shall provide recommendations to the legislature by February 15, 2009, for provider standards for personal care assistant services as described in section ~~256B.0655~~ 256B.0659.

Sec. 3. Minnesota Statutes 2008, section 176.011, subdivision 9, is amended to read:

139.1 Subd. 9. **Employee.** "Employee" means any person who performs services for
139.2 another for hire including the following:
139.3 (1) an alien;
139.4 (2) a minor;
139.5 (3) a sheriff, deputy sheriff, police officer, firefighter, county highway engineer, and
139.6 peace officer while engaged in the enforcement of peace or in the pursuit or capture of a
139.7 person charged with or suspected of crime;
139.8 (4) a person requested or commanded to aid an officer in arresting or retaking a
139.9 person who has escaped from lawful custody, or in executing legal process, in which
139.10 cases, for purposes of calculating compensation under this chapter, the daily wage of the
139.11 person shall be the prevailing wage for similar services performed by paid employees;
139.12 (5) a county assessor;
139.13 (6) an elected or appointed official of the state, or of a county, city, town, school
139.14 district, or governmental subdivision in the state. An officer of a political subdivision
139.15 elected or appointed for a regular term of office, or to complete the unexpired portion of a
139.16 regular term, shall be included only after the governing body of the political subdivision
139.17 has adopted an ordinance or resolution to that effect;
139.18 (7) an executive officer of a corporation, except those executive officers excluded
139.19 by section 176.041;
139.20 (8) a voluntary uncompensated worker, other than an inmate, rendering services in
139.21 state institutions under the commissioners of human services and corrections similar to
139.22 those of officers and employees of the institutions, and whose services have been accepted
139.23 or contracted for by the commissioner of human services or corrections as authorized by
139.24 law. In the event of injury or death of the worker, the daily wage of the worker, for the
139.25 purpose of calculating compensation under this chapter, shall be the usual wage paid at
139.26 the time of the injury or death for similar services in institutions where the services are
139.27 performed by paid employees;
139.28 (9) a voluntary uncompensated worker engaged in emergency management as
139.29 defined in section 12.03, subdivision 4, who is:
139.30 (i) registered with the state or any political subdivision of it, according to the
139.31 procedures set forth in the state or political subdivision emergency operations plan; and
139.32 (ii) acting under the direction and control of, and within the scope of duties approved
139.33 by, the state or political subdivision.

139.34 The daily wage of the worker, for the purpose of calculating compensation under this
139.35 chapter, shall be the usual wage paid at the time of the injury or death for similar services
139.36 performed by paid employees;

140.1 (10) a voluntary uncompensated worker participating in a program established by a
140.2 local social services agency. For purposes of this clause, "local social services agency"
140.3 means any agency established under section 393.01. In the event of injury or death of the
140.4 worker, the wage of the worker, for the purpose of calculating compensation under this
140.5 chapter, shall be the usual wage paid in the county at the time of the injury or death for
140.6 similar services performed by paid employees working a normal day and week;
140.7 (11) a voluntary uncompensated worker accepted by the commissioner of natural
140.8 resources who is rendering services as a volunteer pursuant to section 84.089. The daily
140.9 wage of the worker for the purpose of calculating compensation under this chapter, shall
140.10 be the usual wage paid at the time of injury or death for similar services performed by
140.11 paid employees;
140.12 (12) a voluntary uncompensated worker in the building and construction industry
140.13 who renders services for joint labor-management nonprofit community service projects.
140.14 The daily wage of the worker for the purpose of calculating compensation under this
140.15 chapter shall be the usual wage paid at the time of injury or death for similar services
140.16 performed by paid employees;
140.17 (13) a member of the military forces, as defined in section 190.05, while in state
140.18 active service, as defined in section 190.05, subdivision 5a. The daily wage of the member
140.19 for the purpose of calculating compensation under this chapter shall be based on the
140.20 member's usual earnings in civil life. If there is no evidence of previous occupation or
140.21 earning, the trier of fact shall consider the member's earnings as a member of the military
140.22 forces;
140.23 (14) a voluntary uncompensated worker, accepted by the director of the Minnesota
140.24 Historical Society, rendering services as a volunteer, pursuant to chapter 138. The daily
140.25 wage of the worker, for the purposes of calculating compensation under this chapter,
140.26 shall be the usual wage paid at the time of injury or death for similar services performed
140.27 by paid employees;
140.28 (15) a voluntary uncompensated worker, other than a student, who renders services
140.29 at the Minnesota State Academy for the Deaf or the Minnesota State Academy for the
140.30 Blind, and whose services have been accepted or contracted for by the commissioner of
140.31 education, as authorized by law. In the event of injury or death of the worker, the daily
140.32 wage of the worker, for the purpose of calculating compensation under this chapter, shall
140.33 be the usual wage paid at the time of the injury or death for similar services performed in
140.34 institutions by paid employees;
140.35 (16) a voluntary uncompensated worker, other than a resident of the veterans home,
140.36 who renders services at a Minnesota veterans home, and whose services have been

141.1 accepted or contracted for by the commissioner of veterans affairs, as authorized by law.
141.2 In the event of injury or death of the worker, the daily wage of the worker, for the purpose
141.3 of calculating compensation under this chapter, shall be the usual wage paid at the time of
141.4 the injury or death for similar services performed in institutions by paid employees;

141.5 (17) a worker performing services under section ~~256B.0655~~ 256B.0659 for a
141.6 recipient in the home of the recipient or in the community under section 256B.0625,
141.7 subdivision 19a, who is paid from government funds through a fiscal intermediary under
141.8 section ~~256B.0655, subdivision 7~~ 256B.0659, subdivision 33. For purposes of maintaining
141.9 workers' compensation insurance, the employer of the worker is as designated in law
141.10 by the commissioner of the Department of Human Services, notwithstanding any other
141.11 law to the contrary;

141.12 (18) students enrolled in and regularly attending the Medical School of the
141.13 University of Minnesota in the graduate school program or the postgraduate program. The
141.14 students shall not be considered employees for any other purpose. In the event of the
141.15 student's injury or death, the weekly wage of the student for the purpose of calculating
141.16 compensation under this chapter, shall be the annualized educational stipend awarded to
141.17 the student, divided by 52 weeks. The institution in which the student is enrolled shall
141.18 be considered the "employer" for the limited purpose of determining responsibility for
141.19 paying benefits under this chapter;

141.20 (19) a faculty member of the University of Minnesota employed for an academic
141.21 year is also an employee for the period between that academic year and the succeeding
141.22 academic year if:

141.23 (a) the member has a contract or reasonable assurance of a contract from the
141.24 University of Minnesota for the succeeding academic year; and

141.25 (b) the personal injury for which compensation is sought arises out of and in the
141.26 course of activities related to the faculty member's employment by the University of
141.27 Minnesota;

141.28 (20) a worker who performs volunteer ambulance driver or attendant services is an
141.29 employee of the political subdivision, nonprofit hospital, nonprofit corporation, or other
141.30 entity for which the worker performs the services. The daily wage of the worker for the
141.31 purpose of calculating compensation under this chapter shall be the usual wage paid at the
141.32 time of injury or death for similar services performed by paid employees;

141.33 (21) a voluntary uncompensated worker, accepted by the commissioner of
141.34 administration, rendering services as a volunteer at the Department of Administration. In
141.35 the event of injury or death of the worker, the daily wage of the worker, for the purpose of

142.1 calculating compensation under this chapter, shall be the usual wage paid at the time of the
142.2 injury or death for similar services performed in institutions by paid employees;
142.3 (22) a voluntary uncompensated worker rendering service directly to the Pollution
142.4 Control Agency. The daily wage of the worker for the purpose of calculating compensation
142.5 payable under this chapter is the usual going wage paid at the time of injury or death for
142.6 similar services if the services are performed by paid employees;
142.7 (23) a voluntary uncompensated worker while volunteering services as a first
142.8 responder or as a member of a law enforcement assistance organization while acting
142.9 under the supervision and authority of a political subdivision. The daily wage of the
142.10 worker for the purpose of calculating compensation payable under this chapter is the
142.11 usual going wage paid at the time of injury or death for similar services if the services
142.12 are performed by paid employees;
142.13 (24) a voluntary uncompensated member of the civil air patrol rendering service on
142.14 the request and under the authority of the state or any of its political subdivisions. The
142.15 daily wage of the member for the purposes of calculating compensation payable under this
142.16 chapter is the usual going wage paid at the time of injury or death for similar services if
142.17 the services are performed by paid employees; and
142.18 (25) a Minnesota Responds Medical Reserve Corps volunteer, as provided in
142.19 sections 145A.04 and 145A.06, responding at the request of or engaged in training
142.20 conducted by the commissioner of health. The daily wage of the volunteer for the purposes
142.21 of calculating compensation payable under this chapter is established in section 145A.06.
142.22 A person who qualifies under this clause and who may also qualify under another clause
142.23 of this subdivision shall receive benefits in accordance with this clause.
142.24 If it is difficult to determine the daily wage as provided in this subdivision, the trier
142.25 of fact may determine the wage upon which the compensation is payable.

142.26 Sec. 4. Minnesota Statutes 2008, section 245C.03, subdivision 2, is amended to read:
142.27 Subd. 2. **Personal care provider organizations.** The commissioner shall conduct
142.28 background studies on any individual required under sections 256B.0651 ~~and 256B.0653~~
142.29 to 256B.0656 and 256B.0659 to have a background study completed under this chapter.

142.30 Sec. 5. Minnesota Statutes 2008, section 245C.04, subdivision 3, is amended to read:
142.31 Subd. 3. **Personal care provider organizations.** (a) The commissioner shall
142.32 conduct a background study of an individual required to be studied under section 245C.03,
142.33 subdivision 2, at least upon application for initial enrollment under sections 256B.0651
142.34 ~~and 256B.0653~~ to 256B.0656 and 256B.0659.

143.1 (b) Organizations required to initiate background studies under sections 256B.0651
143.2 ~~and 256B.0653~~ to 256B.0656 and 256B.0659 for individuals described in section 245C.03,
143.3 subdivision 2, must submit a completed background study form to the commissioner
143.4 before those individuals begin a position allowing direct contact with persons served
143.5 by the organization.

143.6 Sec. 6. Minnesota Statutes 2008, section 245C.10, subdivision 3, is amended to read:
143.7 Subd. 3. **Personal care provider organizations.** The commissioner shall recover
143.8 the cost of background studies initiated by a personal care provider organization under
143.9 sections 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659 through a fee of no
143.10 more than $20 per study charged to the organization responsible for submitting the
143.11 background study form. The fees collected under this subdivision are appropriated to the
143.12 commissioner for the purpose of conducting background studies.

143.13 Sec. 7. Minnesota Statutes 2008, section 256B.04, subdivision 16, is amended to read:
143.14 Subd. 16. **Personal care services.** (a) Notwithstanding any contrary language in
143.15 this paragraph, the commissioner of human services and the commissioner of health shall
143.16 jointly promulgate rules to be applied to the licensure of personal care services provided
143.17 under the medical assistance program. The rules shall consider standards for personal care
143.18 services that are based on the World Institute on Disability's recommendations regarding
143.19 personal care services. These rules shall at a minimum consider the standards and
143.20 requirements adopted by the commissioner of health under section 144A.45, which the
143.21 commissioner of human services determines are applicable to the provision of personal
143.22 care services, in addition to other standards or modifications which the commissioner of
143.23 human services determines are appropriate.
143.24 The commissioner of human services shall establish an advisory group including
143.25 personal care consumers and providers to provide advice regarding which standards or
143.26 modifications should be adopted. The advisory group membership must include not less
143.27 than 15 members, of which at least 60 percent must be consumers of personal care services
143.28 and representatives of recipients with various disabilities and diagnoses and ages. At least
143.29 51 percent of the members of the advisory group must be recipients of personal care.
143.30 The commissioner of human services may contract with the commissioner of health
143.31 to enforce the jointly promulgated licensure rules for personal care service providers.
143.32 Prior to final promulgation of the joint rule the commissioner of human services
143.33 shall report preliminary findings along with any comments of the advisory group and a

144.1 plan for monitoring and enforcement by the Department of Health to the legislature by
144.2 February 15, 1992.
144.3 Limits on the extent of personal care services that may be provided to an individual
144.4 must be based on the cost-effectiveness of the services in relation to the costs of inpatient
144.5 hospital care, nursing home care, and other available types of care. The rules must
144.6 provide, at a minimum:
144.7 (1) that agencies be selected to contract with or employ and train staff to provide and
144.8 supervise the provision of personal care services;
144.9 (2) that agencies employ or contract with a qualified applicant that a qualified
144.10 recipient proposes to the agency as the recipient's choice of assistant;
144.11 (3) that agencies bill the medical assistance program for a personal care service
144.12 by a personal care assistant and supervision by a qualified professional supervising the
144.13 personal care assistant unless the recipient selects the fiscal agent option under section
144.14 ~~256B.0655, subdivision 7~~ 256B.0659, subdivision 33;
144.15 (4) that agencies establish a grievance mechanism; and
144.16 (5) that agencies have a quality assurance program.
144.17 (b) The commissioner may waive the requirement for the provision of personal care
144.18 services through an agency in a particular county, when there are less than two agencies
144.19 providing services in that county and shall waive the requirement for personal care
144.20 assistants required to join an agency for the first time during 1993 when personal care
144.21 services are provided under a relative hardship waiver under Minnesota Statutes 1992,
144.22 section 256B.0627, subdivision 4, paragraph (b), clause (7), and at least two agencies
144.23 providing personal care services have refused to employ or contract with the independent
144.24 personal care assistant.

144.25 Sec. 8. Minnesota Statutes 2008, section 256B.055, subdivision 12, is amended to read:
144.26 Subd. 12. **Disabled children.** (a) A person is eligible for medical assistance if the
144.27 person is under age 19 and qualifies as a disabled individual under United States Code,
144.28 title 42, section 1382c(a), and would be eligible for medical assistance under the state
144.29 plan if residing in a medical institution, and the child requires a level of care provided in
144.30 a hospital, nursing facility, or intermediate care facility for persons with developmental
144.31 disabilities, for whom home care is appropriate, provided that the cost to medical
144.32 assistance under this section is not more than the amount that medical assistance would pay
144.33 for if the child resides in an institution. After the child is determined to be eligible under
144.34 this section, the commissioner shall review the child's disability under United States Code,
144.35 title 42, section 1382c(a) and level of care defined under this section no more often than

145.1 annually and may elect, based on the recommendation of health care professionals under
145.2 contract with the state medical review team, to extend the review of disability and level of
145.3 care up to a maximum of four years. The commissioner's decision on the frequency of
145.4 continuing review of disability and level of care is not subject to administrative appeal
145.5 under section 256.045. The county agency shall send a notice of disability review to the
145.6 enrollee six months prior to the date the recertification of disability is due. Nothing in this
145.7 subdivision shall be construed as affecting other redeterminations of medical assistance
145.8 eligibility under this chapter and annual cost-effective reviews under this section.

145.9 (b) For purposes of this subdivision, "hospital" means an institution as defined
145.10 in section 144.696, subdivision 3, 144.55, subdivision 3, or Minnesota Rules, part
145.11 4640.3600, and licensed pursuant to sections 144.50 to 144.58. For purposes of this
145.12 subdivision, a child requires a level of care provided in a hospital if the child is determined
145.13 by the commissioner to need an extensive array of health services, including mental health
145.14 services, for an undetermined period of time, whose health condition requires frequent
145.15 monitoring and treatment by a health care professional or by a person supervised by a
145.16 health care professional, who would reside in a hospital or require frequent hospitalization
145.17 if these services were not provided, and the daily care needs are more complex than
145.18 a nursing facility level of care.

145.19 A child with serious emotional disturbance requires a level of care provided in a
145.20 hospital if the commissioner determines that the individual requires 24-hour supervision
145.21 because the person exhibits recurrent or frequent suicidal or homicidal ideation or
145.22 behavior, recurrent or frequent psychosomatic disorders or somatopsychic disorders that
145.23 may become life threatening, recurrent or frequent severe socially unacceptable behavior
145.24 associated with psychiatric disorder, ongoing and chronic psychosis or severe, ongoing
145.25 and chronic developmental problems requiring continuous skilled observation, or severe
145.26 disabling symptoms for which office-centered outpatient treatment is not adequate, and
145.27 which overall severely impact the individual's ability to function.

145.28 (c) For purposes of this subdivision, "nursing facility" means a facility which
145.29 provides nursing care as defined in section 144A.01, subdivision 5, licensed pursuant to
145.30 sections 144A.02 to 144A.10, which is appropriate if a person is in active restorative
145.31 treatment; is in need of special treatments provided or supervised by a licensed nurse; or
145.32 has unpredictable episodes of active disease processes requiring immediate judgment
145.33 by a licensed nurse. For purposes of this subdivision, a child requires the level of care
145.34 provided in a nursing facility if the child is determined by the commissioner to meet
145.35 the requirements of the preadmission screening assessment document under section
145.36 256B.0911 and the home care independent rating document under section ~~256B.0655,~~

146.1 ~~subdivision 4, clause (3)~~ 256B.0659, adjusted to address age-appropriate standards for
146.2 children age 18 and under, pursuant to section ~~256B.0655, subdivision 3~~ 256B.0659.
146.3 (d) For purposes of this subdivision, "intermediate care facility for persons with
146.4 developmental disabilities" or "ICF/MR" means a program licensed to provide services to
146.5 persons with developmental disabilities under section 252.28, and chapter 245A, and a
146.6 physical plant licensed as a supervised living facility under chapter 144, which together
146.7 are certified by the Minnesota Department of Health as meeting the standards in Code of
146.8 Federal Regulations, title 42, part 483, for an intermediate care facility which provides
146.9 services for persons with developmental disabilities who require 24-hour supervision
146.10 and active treatment for medical, behavioral, or habilitation needs. For purposes of this
146.11 subdivision, a child requires a level of care provided in an ICF/MR if the commissioner
146.12 finds that the child has a developmental disability in accordance with section 256B.092,
146.13 is in need of a 24-hour plan of care and active treatment similar to persons with
146.14 developmental disabilities, and there is a reasonable indication that the child will need
146.15 ICF/MR services.
146.16 (e) For purposes of this subdivision, a person requires the level of care provided
146.17 in a nursing facility if the person requires 24-hour monitoring or supervision and a plan
146.18 of mental health treatment because of specific symptoms or functional impairments
146.19 associated with a serious mental illness or disorder diagnosis, which meet severity criteria
146.20 for mental health established by the commissioner and published in March 1997 as
146.21 the Minnesota Mental Health Level of Care for Children and Adolescents with Severe
146.22 Emotional Disorders.
146.23 (f) The determination of the level of care needed by the child shall be made by
146.24 the commissioner based on information supplied to the commissioner by the parent or
146.25 guardian, the child's physician or physicians, and other professionals as requested by the
146.26 commissioner. The commissioner shall establish a screening team to conduct the level of
146.27 care determinations according to this subdivision.
146.28 (g) If a child meets the conditions in paragraph (b), (c), (d), or (e), the commissioner
146.29 must assess the case to determine whether:
146.30 (1) the child qualifies as a disabled individual under United States Code, title 42,
146.31 section 1382c(a), and would be eligible for medical assistance if residing in a medical
146.32 institution; and
146.33 (2) the cost of medical assistance services for the child, if eligible under this
146.34 subdivision, would not be more than the cost to medical assistance if the child resides in a
146.35 medical institution to be determined as follows:

(i) for a child who requires a level of care provided in an ICF/MR, the cost of care for the child in an institution shall be determined using the average payment rate established for the regional treatment centers that are certified as ICF's/MR;

(ii) for a child who requires a level of care provided in an inpatient hospital setting according to paragraph (b), cost-effectiveness shall be determined according to Minnesota Rules, part 9505.3520, items F and G; and

(iii) for a child who requires a level of care provided in a nursing facility according to paragraph (c) or (e), cost-effectiveness shall be determined according to Minnesota Rules, part 9505.3040, except that the nursing facility average rate shall be adjusted to reflect rates which would be paid for children under age 16. The commissioner may authorize an amount up to the amount medical assistance would pay for a child referred to the commissioner by the preadmission screening team under section 256B.0911.

(h) Children eligible for medical assistance services under section 256B.055, subdivision 12, as of June 30, 1995, must be screened according to the criteria in this subdivision prior to January 1, 1996. Children found to be ineligible may not be removed from the program until January 1, 1996.

Sec. 9. Minnesota Statutes 2008, section 256B.0621, subdivision 2, is amended to read:

Subd. 2. **Targeted case management; definitions.** For purposes of subdivisions 3 to 10, the following terms have the meanings given them:

(1) "home care service recipients" means those individuals receiving the following services under sections 256B.0651 to 256B.0656 and 256B.0659: skilled nursing visits, home health aide visits, private duty nursing, personal care assistants, or therapies provided through a home health agency;

(2) "home care targeted case management" means the provision of targeted case management services for the purpose of assisting home care service recipients to gain access to needed services and supports so that they may remain in the community;

(3) "institutions" means hospitals, consistent with Code of Federal Regulations, title 42, section 440.10; regional treatment center inpatient services, consistent with section 245.474; nursing facilities; and intermediate care facilities for persons with developmental disabilities;

(4) "relocation targeted case management" includes the provision of both county targeted case management and public or private vendor service coordination services for the purpose of assisting recipients to gain access to needed services and supports if they choose to move from an institution to the community. Relocation targeted case management may be provided during the lesser of:

148.1 (i) the last 180 consecutive days of an eligible recipient's institutional stay; or
148.2 (ii) the limits and conditions which apply to federal Medicaid funding for this
148.3 service; and
148.4 (5) "targeted case management" means case management services provided to help
148.5 recipients gain access to needed medical, social, educational, and other services and
148.6 supports.

148.7 Sec. 10. Minnesota Statutes 2008, section 256B.0652, subdivision 3, is amended to
148.8 read:
148.9 Subd. 3. **Assessment and prior authorization process.** Effective January 1, 1996,
148.10 for purposes of providing informed choice, coordinating of local planning decisions, and
148.11 streamlining administrative requirements, the assessment and prior authorization process
148.12 for persons receiving both home care and home and community-based waivered services
148.13 for persons with developmental disabilities shall meet the requirements of sections
148.14 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659 with the following exceptions:
148.15 (a) Upon request for home care services and subsequent assessment by the public
148.16 health nurse under sections 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659,
148.17 the public health nurse shall participate in the screening process, as appropriate, and,
148.18 if home care services are determined to be necessary, participate in the development
148.19 of a service plan coordinating the need for home care and home and community-based
148.20 waivered services with the assigned county case manager, the recipient of services, and
148.21 the recipient's legal representative, if any.
148.22 (b) The public health nurse shall give prior authorization for home care services
148.23 to the extent that home care services are:
148.24 (1) medically necessary;
148.25 (2) chosen by the recipient and their legal representative, if any, from the array of
148.26 home care and home and community-based waivered services available;
148.27 (3) coordinated with other services to be received by the recipient as described
148.28 in the service plan; and
148.29 (4) provided within the county's reimbursement limits for home care and home and
148.30 community-based waivered services for persons with developmental disabilities.
148.31 (c) If the public health agency is or may be the provider of home care services to the
148.32 recipient, the public health agency shall provide the commissioner of human services with
148.33 a written plan that specifies how the assessment and prior authorization process will be
148.34 held separate and distinct from the provision of services.

149.1 Sec. 11. Minnesota Statutes 2008, section 256B.0657, subdivision 2, is amended to
149.2 read:

149.3 Subd. 2. **Eligibility.** (a) The self-directed supports option is available to a person
149.4 who:

149.5 (1) is a recipient of medical assistance as determined under sections 256B.055,
149.6 256B.056, and 256B.057, subdivision 9;

149.7 (2) is eligible for personal care assistant services under section ~~256B.0655~~
149.8 256B.0659;

149.9 (3) lives in the person's own apartment or home, which is not owned, operated, or
149.10 controlled by a provider of services not related by blood or marriage;

149.11 (4) has the ability to hire, fire, supervise, establish staff compensation for, and
149.12 manage the individuals providing services, and to choose and obtain items, related
149.13 services, and supports as described in the participant's plan. If the recipient is not able to
149.14 carry out these functions but has a legal guardian or parent to carry them out, the guardian
149.15 or parent may fulfill these functions on behalf of the recipient; and

149.16 (5) has not been excluded or disenrolled by the commissioner.

149.17 (b) The commissioner may disenroll or exclude recipients, including guardians and
149.18 parents, under the following circumstances:

149.19 (1) recipients who have been restricted by the Primary Care Utilization Review
149.20 Committee may be excluded for a specified time period;

149.21 (2) recipients who exit the self-directed supports option during the recipient's
149.22 service plan year shall not access the self-directed supports option for the remainder of
149.23 that service plan year; and

149.24 (3) when the department determines that the recipient cannot manage recipient
149.25 responsibilities under the program.

149.26 Sec. 12. Minnesota Statutes 2008, section 256B.0657, subdivision 6, is amended to
149.27 read:

149.28 Subd. 6. **Services covered.** (a) Services covered under the self-directed supports
149.29 option include:

149.30 (1) personal care assistant services under section ~~256B.0655~~ 256B.0659; and

149.31 (2) items, related services, and supports, including assistive technology, that increase
149.32 independence or substitute for human assistance to the extent expenditures would
149.33 otherwise be used for human assistance.

149.34 (b) Items, supports, and related services purchased under this option shall not be
149.35 considered home care services for the purposes of section 144A.43.

Sec. 13. Minnesota Statutes 2008, section 256B.0657, subdivision 8, is amended to read:

Subd. 8. **Self-directed budget requirements.** The budget for the provision of the self-directed service option shall be equal to the greater of either:

(1) the annual amount of personal care assistant services under section ~~256B.0655~~ 256B.0659 that the recipient has used in the most recent 12-month period; or

(2) the amount determined using the consumer support grant methodology under section 256.476, subdivision 11, except that the budget amount shall include the federal and nonfederal share of the average service costs.

Sec. 14. Minnesota Statutes 2008, section 256B.49, subdivision 17, is amended to read:

Subd. 17. **Cost of services and supports.** (a) The commissioner shall ensure that the average per capita expenditures estimated in any fiscal year for home and community-based waiver recipients does not exceed the average per capita expenditures that would have been made to provide institutional services for recipients in the absence of the waiver.

(b) The commissioner shall implement on January 1, 2002, one or more aggregate, need-based methods for allocating to local agencies the home and community-based waivered service resources available to support recipients with disabilities in need of the level of care provided in a nursing facility or a hospital. The commissioner shall allocate resources to single counties and county partnerships in a manner that reflects consideration of:

(1) an incentive-based payment process for achieving outcomes;

(2) the need for a state-level risk pool;

(3) the need for retention of management responsibility at the state agency level; and

(4) a phase-in strategy as appropriate.

(c) Until the allocation methods described in paragraph (b) are implemented, the annual allowable reimbursement level of home and community-based waiver services shall be the greater of:

(1) the statewide average payment amount which the recipient is assigned under the waiver reimbursement system in place on June 30, 2001, modified by the percentage of any provider rate increase appropriated for home and community-based services; or

(2) an amount approved by the commissioner based on the recipient's extraordinary needs that cannot be met within the current allowable reimbursement level. The increased reimbursement level must be necessary to allow the recipient to be discharged from an institution or to prevent imminent placement in an institution. The additional

151.1 reimbursement may be used to secure environmental modifications; assistive technology
151.2 and equipment; and increased costs for supervision, training, and support services
151.3 necessary to address the recipient's extraordinary needs. The commissioner may approve
151.4 an increased reimbursement level for up to one year of the recipient's relocation from an
151.5 institution or up to six months of a determination that a current waiver recipient is at
151.6 imminent risk of being placed in an institution.
151.7 (d) Beginning July 1, 2001, medically necessary private duty nursing services
151.8 will be authorized under this section as complex and regular care according to sections
151.9 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659. The rate established by the
151.10 commissioner for registered nurse or licensed practical nurse services under any home and
151.11 community-based waiver as of January 1, 2001, shall not be reduced.

151.12 Sec. 15. Minnesota Statutes 2008, section 256B.501, subdivision 4a, is amended to
151.13 read:
151.14 Subd. 4a. **Inclusion of home care costs in waiver rates.** The commissioner
151.15 shall adjust the limits of the established average daily reimbursement rates for waivered
151.16 services to include the cost of home care services that may be provided to waivered
151.17 services recipients. This adjustment must be used to maintain or increase services and
151.18 shall not be used by county agencies for inflation increases for waivered services vendors.
151.19 Home care services referenced in this section are those listed in section 256B.0651,
151.20 subdivision 2. The average daily reimbursement rates established in accordance with
151.21 the provisions of this subdivision apply only to the combined average, daily costs of
151.22 waivered and home care services and do not change home care limitations under sections
151.23 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659. Waivered services recipients
151.24 receiving home care as of June 30, 1992, shall not have the amount of their services
151.25 reduced as a result of this section.

151.26 Sec. 16. Minnesota Statutes 2008, section 256G.02, subdivision 6, is amended to read:
151.27 Subd. 6. **Excluded time.** "Excluded time" means:
151.28 (a) any period an applicant spends in a hospital, sanitarium, nursing home, shelter
151.29 other than an emergency shelter, halfway house, foster home, semi-independent living
151.30 domicile or services program, residential facility offering care, board and lodging facility
151.31 or other institution for the hospitalization or care of human beings, as defined in section
151.32 144.50, 144A.01, or 245A.02, subdivision 14; maternity home, battered women's shelter,
151.33 or correctional facility; or any facility based on an emergency hold under sections
151.34 253B.05, subdivisions 1 and 2, and 253B.07, subdivision 6;

(b) any period an applicant spends on a placement basis in a training and habilitation program, including a rehabilitation facility or work or employment program as defined in section 268A.01; or receiving personal care assistant services pursuant to section ~~256B.0655, subdivision 2~~ 256B.0659; semi-independent living services provided under section 252.275, and Minnesota Rules, parts 9525.0500 to 9525.0660; day training and habilitation programs and assisted living services; and

(c) any placement for a person with an indeterminate commitment, including independent living.

Sec. 17. Minnesota Statutes 2008, section 256I.05, subdivision 1a, is amended to read:

Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section 256I.04, subdivision 3, the county agency may negotiate a payment not to exceed $426.37 for other services necessary to provide room and board provided by the group residence if the residence is licensed by or registered by the Department of Health, or licensed by the Department of Human Services to provide services in addition to room and board, and if the provider of services is not also concurrently receiving funding for services for a recipient under a home and community-based waiver under title XIX of the Social Security Act; or funding from the medical assistance program under section ~~256B.0655, subdivision 2~~ 256B.0659, for personal care services for residents in the setting; or residing in a setting which receives funding under Minnesota Rules, parts 9535.2000 to 9535.3000. If funding is available for other necessary services through a home and community-based waiver, or personal care services under section ~~256B.0655, subdivision 2~~ 256B.0659, then the GRH rate is limited to the rate set in subdivision 1. Unless otherwise provided in law, in no case may the supplementary service rate exceed $426.37. The registration and licensure requirement does not apply to establishments which are exempt from state licensure because they are located on Indian reservations and for which the tribe has prescribed health and safety requirements. Service payments under this section may be prohibited under rules to prevent the supplanting of federal funds with state funds. The commissioner shall pursue the feasibility of obtaining the approval of the Secretary of Health and Human Services to provide home and community-based waiver services under title XIX of the Social Security Act for residents who are not eligible for an existing home and community-based waiver due to a primary diagnosis of mental illness or chemical dependency and shall apply for a waiver if it is determined to be cost-effective.

(b) The commissioner is authorized to make cost-neutral transfers from the GRH fund for beds under this section to other funding programs administered by the department after consultation with the county or counties in which the affected beds are located.

153.1 The commissioner may also make cost-neutral transfers from the GRH fund to county
153.2 human service agencies for beds permanently removed from the GRH census under a plan
153.3 submitted by the county agency and approved by the commissioner. The commissioner
153.4 shall report the amount of any transfers under this provision annually to the legislature.
153.5 (c) The provisions of paragraph (b) do not apply to a facility that has its
153.6 reimbursement rate established under section 256B.431, subdivision 4, paragraph (c).

153.7 Sec. 18. Minnesota Statutes 2008, section 256J.45, subdivision 3, is amended to read:
153.8 Subd. 3. **Good cause exemptions for not attending orientation.** (a) The county
153.9 agency shall not impose the sanction under section 256J.46 if it determines that the
153.10 participant has good cause for failing to attend orientation. Good cause exists when:
153.11 (1) appropriate child care is not available;
153.12 (2) the participant is ill or injured;
153.13 (3) a family member is ill and needs care by the participant that prevents the
153.14 participant from attending orientation. For a caregiver with a child or adult in the
153.15 household who meets the disability or medical criteria for home care services under
153.16 section ~~256B.0655, subdivision 1c~~ 256B.0659, or a home and community-based waiver
153.17 services program under chapter 256B, or meets the criteria for severe emotional
153.18 disturbance under section 245.4871, subdivision 6, or for serious and persistent mental
153.19 illness under section 245.462, subdivision 20, paragraph (c), good cause also exists when
153.20 an interruption in the provision of those services occurs which prevents the participant
153.21 from attending orientation;
153.22 (4) the caregiver is unable to secure necessary transportation;
153.23 (5) the caregiver is in an emergency situation that prevents orientation attendance;
153.24 (6) the orientation conflicts with the caregiver's work, training, or school schedule; or
153.25 (7) the caregiver documents other verifiable impediments to orientation attendance
153.26 beyond the caregiver's control.
153.27 (b) Counties must work with clients to provide child care and transportation
153.28 necessary to ensure a caregiver has every opportunity to attend orientation.

153.29 Sec. 19. Minnesota Statutes 2008, section 604A.33, subdivision 1, is amended to read:
153.30 Subdivision 1. **Application.** This section applies to residential treatment programs
153.31 for children or group homes for children licensed under chapter 245A, residential
153.32 services and programs for juveniles licensed under section 241.021, providers licensed
153.33 pursuant to sections 144A.01 to 144A.33 or sections 144A.43 to 144A.47, personal care
153.34 provider organizations under section ~~256B.0655, subdivision 1g~~ 256B.0659, providers

154.1 of day training and habilitation services under sections 252.40 to 252.46, board and
154.2 lodging facilities licensed under chapter 157, intermediate care facilities for persons with
154.3 developmental disabilities, and other facilities licensed to provide residential services to
154.4 persons with developmental disabilities.

154.5 Sec. 20. Minnesota Statutes 2008, section 609.232, subdivision 11, is amended to read:
154.6 Subd. 11. **Vulnerable adult.** "Vulnerable adult" means any person 18 years of
154.7 age or older who:
154.8 (1) is a resident inpatient of a facility;
154.9 (2) receives services at or from a facility required to be licensed to serve adults
154.10 under sections 245A.01 to 245A.15, except that a person receiving outpatient services for
154.11 treatment of chemical dependency or mental illness, or one who is committed as a sexual
154.12 psychopathic personality or as a sexually dangerous person under chapter 253B, is not
154.13 considered a vulnerable adult unless the person meets the requirements of clause (4);
154.14 (3) receives services from a home care provider required to be licensed under section
154.15 144A.46; or from a person or organization that exclusively offers, provides, or arranges
154.16 for personal care assistant services under the medical assistance program as authorized
154.17 under sections 256B.04, subdivision 16, 256B.0625, subdivision 19a, 256B.0651~~, and~~
154.18 ~~256B.0653~~ to 256B.0656<u> and 256B.0659</u>; or
154.19 (4) regardless of residence or whether any type of service is received, possesses a
154.20 physical or mental infirmity or other physical, mental, or emotional dysfunction:
154.21 (i) that impairs the individual's ability to provide adequately for the individual's
154.22 own care without assistance, including the provision of food, shelter, clothing, health
154.23 care, or supervision; and
154.24 (ii) because of the dysfunction or infirmity and the need for assistance, the individual
154.25 has an impaired ability to protect the individual from maltreatment.

154.26 Sec. 21. Minnesota Statutes 2008, section 626.5572, subdivision 6, is amended to read:
154.27 Subd. 6. **Facility.** (a) "Facility" means a hospital or other entity required to be
154.28 licensed under sections 144.50 to 144.58; a nursing home required to be licensed to
154.29 serve adults under section 144A.02; a residential or nonresidential facility required to
154.30 be licensed to serve adults under sections 245A.01 to 245A.16; a home care provider
154.31 licensed or required to be licensed under section 144A.46; a hospice provider licensed
154.32 under sections 144A.75 to 144A.755; or a person or organization that exclusively offers,
154.33 provides, or arranges for personal care assistant services under the medical assistance

155.1 program as authorized under sections 256B.04, subdivision 16, 256B.0625, subdivision
155.2 19a, 256B.0651~~, and 256B.0653~~ to 256B.0656, and 256B.0659.
155.3 (b) For home care providers and personal care attendants, the term "facility" refers
155.4 to the provider or person or organization that exclusively offers, provides, or arranges for
155.5 personal care services, and does not refer to the client's home or other location at which
155.6 services are rendered.

155.7 Sec. 22. Minnesota Statutes 2008, section 626.5572, subdivision 21, is amended to
155.8 read:
155.9 Subd. 21. **Vulnerable adult.** "Vulnerable adult" means any person 18 years of
155.10 age or older who:
155.11 (1) is a resident or inpatient of a facility;
155.12 (2) receives services at or from a facility required to be licensed to serve adults
155.13 under sections 245A.01 to 245A.15, except that a person receiving outpatient services for
155.14 treatment of chemical dependency or mental illness, or one who is served in the Minnesota
155.15 sex offender program on a court-hold order for commitment, or is committed as a sexual
155.16 psychopathic personality or as a sexually dangerous person under chapter 253B, is not
155.17 considered a vulnerable adult unless the person meets the requirements of clause (4);
155.18 (3) receives services from a home care provider required to be licensed under section
155.19 144A.46; or from a person or organization that exclusively offers, provides, or arranges
155.20 for personal care assistant services under the medical assistance program as authorized
155.21 under sections 256B.04, subdivision 16, 256B.0625, subdivision 19a, 256B.0651, ~~and~~
155.22 256B.0653 to 256B.0656, and 256B.0659; or
155.23 (4) regardless of residence or whether any type of service is received, possesses a
155.24 physical or mental infirmity or other physical, mental, or emotional dysfunction:
155.25 (i) that impairs the individual's ability to provide adequately for the individual's
155.26 own care without assistance, including the provision of food, shelter, clothing, health
155.27 care, or supervision; and
155.28 (ii) because of the dysfunction or infirmity and the need for assistance, the individual
155.29 has an impaired ability to protect the individual from maltreatment.

155.30 ARTICLE 8
155.31 CHEMICAL AND MENTAL HEALTH

155.32 Section 1. Minnesota Statutes 2008, section 245.4885, subdivision 1, is amended to
155.33 read:

Subdivision 1. **Admission criteria.** ~~The county board shall,~~ (a) Prior to admission, except in the case of emergency admission, ~~determine the needed level of care for~~ all children referred for treatment of severe emotional disturbance in a treatment foster care setting, residential treatment facility, or informally admitted to a regional treatment center shall undergo an assessment to determine the appropriate level of care if public funds are used to pay for the services. ~~The county board shall also determine the needed level of care for all children admitted to an acute care hospital for treatment of severe emotional disturbance if public funds other than reimbursement under chapters 256B and 256D are used to pay for the services.~~

(b) The county board shall determine the appropriate level of care when county-controlled funds are used to pay for the services. When the child is enrolled in a prepaid health program under section 256B.69, the enrolled child's contracted health plan must determine the appropriate level of care. When the child is an Indian tribal member seeking placement through the tribe in a tribally operated or contracted facility, the tribe must determine the appropriate level of care. When more than one entity bears responsibility for coverage, the entities shall coordinate level of care determination activities to the extent possible.

(c) The level of care determination shall determine whether the proposed treatment:

(1) is necessary;

(2) is appropriate to the child's individual treatment needs;

(3) cannot be effectively provided in the child's home; and

(4) provides a length of stay as short as possible consistent with the individual child's need.

(d) When a level of care determination is conducted, the ~~county board~~ responsible entity may not determine that referral or admission to a treatment foster care setting~~,~~ or residential treatment facility~~, or acute care hospital~~ is not appropriate solely because services were not first provided to the child in a less restrictive setting and the child failed to make progress toward or meet treatment goals in the less restrictive setting. The level of care determination must be based on a diagnostic assessment that includes a functional assessment which evaluates family, school, and community living situations; and an assessment of the child's need for care out of the home using a validated tool which assesses a child's functional status and assigns an appropriate level of care. The validated tool must be approved by the commissioner of human services. If a diagnostic assessment including a functional assessment has been completed by a mental health professional within the past 180 days, a new diagnostic assessment need not be completed unless in the opinion of the current treating mental health professional the child's mental health status

has changed markedly since the assessment was completed. The child's parent shall be notified if an assessment will not be completed and of the reasons. A copy of the notice shall be placed in the child's file. Recommendations developed as part of the level of care determination process shall include specific community services needed by the child and, if appropriate, the child's family, and shall indicate whether or not these services are available and accessible to the child and family.

During the level of care determination process, the child, child's family, or child's legal representative, as appropriate, must be informed of the child's eligibility for case management services and family community support services and that an individual family community support plan is being developed by the case manager, if assigned.

The level of care determination shall comply with section 260C.212. ~~Wherever possible,~~ The parent shall be consulted in the process, unless clinically ~~inappropriate~~ detrimental to the child.

The level of care determination, and placement decision, and recommendations for mental health services must be documented in the child's record.

~~An alternate review process may be approved by the commissioner if the county board demonstrates that an alternate review process has been established by the county board and the times of review, persons responsible for the review, and review criteria are comparable to the standards in clauses (1) to (4).~~

Sec. 2. Minnesota Statutes 2008, section 254A.02, is amended by adding a subdivision to read:

Subd. 8a. **Placing authority.** "Placing authority" means a county, prepaid health plan, or tribal governing board governed by Minnesota Rules, parts 9530.6600 to 9530.6655.

Sec. 3. Minnesota Statutes 2008, section 254A.16, is amended by adding a subdivision to read:

Subd. 6. **Monitoring.** The commissioner shall gather and placing authorities shall provide information to measure compliance with Minnesota Rules, parts 9530.6600 to 9530.6655. The commissioner shall specify the format for data collection to facilitate tracking, aggregating, and using the information.

Sec. 4. Minnesota Statutes 2008, section 254B.03, subdivision 1, is amended to read:

Subdivision 1. **Local agency duties.** (a) Every local agency shall provide chemical dependency services to persons residing within its jurisdiction who meet criteria

158.1 established by the commissioner for placement in a chemical dependency residential or
158.2 nonresidential treatment service. Chemical dependency money must be administered
158.3 by the local agencies according to law and rules adopted by the commissioner under
158.4 sections 14.001 to 14.69.

158.5 (b) In order to contain costs, ~~the county board shall, with the approval of~~ the
158.6 commissioner of human services~~,~~ shall select eligible vendors of chemical dependency
158.7 services who can provide economical and appropriate treatment. Unless the local agency
158.8 is a social services department directly administered by a county or human services board,
158.9 the local agency shall not be an eligible vendor under section 254B.05. The commissioner
158.10 may approve proposals from county boards to provide services in an economical manner
158.11 or to control utilization, with safeguards to ensure that necessary services are provided.
158.12 If a county implements a demonstration or experimental medical services funding plan,
158.13 the commissioner shall transfer the money as appropriate. ~~If a county selects a vendor~~
158.14 ~~located in another state, the county shall ensure that the vendor is in compliance with the~~
158.15 ~~rules governing licensure of programs located in the state.~~

158.16 (c) A culturally specific vendor that provides assessments under a variance under
158.17 Minnesota Rules, part 9530.6610, shall be allowed to provide assessment services to
158.18 persons not covered by the variance.

158.19 **EFFECTIVE DATE.** This section is effective July 1, 2011.

158.20 Sec. 5. Minnesota Statutes 2008, section 254B.03, subdivision 3, is amended to read:

158.21 Subd. 3. **Local agencies to pay state for county share.** Local agencies shall pay
158.22 the state for the county share of the services authorized by the local agency, except when
158.23 the payment is made according to section 254B.09, subdivision 8.

158.24 Sec. 6. Minnesota Statutes 2008, section 254B.03, is amended by adding a subdivision
158.25 to read:

158.26 Subd. 9. **Commissioner to select vendors and set rates.** (a) Effective July 1, 2011,
158.27 the commissioner shall:

158.28 (1) enter into agreements with eligible vendors that:

158.29 (i) meet the standards in section 254B.05, subdivision 1;

158.30 (ii) have good standing in all applicable licensure; and

158.31 (iii) have a current approved provider agreement as a Minnesota health care program
158.32 provider; and

158.33 (2) set rates for services reimbursed under this chapter.

159.1 (b) When setting rates, the commissioner shall consider the complexity and the
159.2 acuity of the problems presented by the client.
159.3 (c) When rates set under this section and rates set under section 254B.09, subdivision
159.4 8, apply to the same treatment placement, section 254B.09, subdivision 8, supersedes.

159.5 Sec. 7. Minnesota Statutes 2008, section 254B.05, subdivision 1, is amended to read:
159.6 Subdivision 1. **Licensure required.** Programs licensed by the commissioner are
159.7 eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors,
159.8 notwithstanding the provisions of section 245A.03. American Indian programs located on
159.9 federally recognized tribal lands that provide chemical dependency primary treatment,
159.10 extended care, transitional residence, or outpatient treatment services, and are licensed by
159.11 tribal government are eligible vendors. Detoxification programs are not eligible vendors.
159.12 Programs that are not licensed as a chemical dependency residential or nonresidential
159.13 treatment program by the commissioner or by tribal government are not eligible vendors.
159.14 To be eligible for payment under the Consolidated Chemical Dependency Treatment Fund,
159.15 a vendor of a chemical dependency service must participate in the Drug and Alcohol
159.16 Abuse Normative Evaluation System and the treatment accountability plan.
159.17 Effective January 1, 2000, vendors of room and board are eligible for chemical
159.18 dependency fund payment if the vendor:
159.19 (1) ~~is certified by the county or tribal governing body as having~~ has rules prohibiting
159.20 residents bringing chemicals into the facility or using chemicals while residing in the
159.21 facility and provide consequences for infractions of those rules;
159.22 (2) has a current contract with a county or tribal governing body;
159.23 (3) is determined to meet applicable health and safety requirements;
159.24 (4) is not a jail or prison; and
159.25 (5) is not concurrently receiving funds under chapter 256I for the recipient.

159.26 **EFFECTIVE DATE.** This section is effective July 1, 2011.

159.27 Sec. 8. Minnesota Statutes 2008, section 254B.09, subdivision 2, is amended to read:
159.28 Subd. 2. **American Indian agreements.** The commissioner may enter into
159.29 agreements with federally recognized tribal units to pay for chemical dependency
159.30 treatment services provided under Laws 1986, chapter 394, sections 8 to 20. The
159.31 agreements must clarify how the governing body of the tribal unit fulfills local agency
159.32 responsibilities regarding:
159.33 ~~(1) selection of eligible vendors under section 254B.03, subdivision 1;~~

160.1 (2) negotiation of agreements that establish vendor services and rates for programs
160.2 located on the tribal governing body's reservation;
160.3 (3) (1) the form and manner of invoicing; and
160.4 (4) (2) provide that only invoices for eligible vendors according to section 254B.05
160.5 will be included in invoices sent to the commissioner for payment, to the extent that
160.6 money allocated under subdivisions 4 and 5 is used.

160.7 **EFFECTIVE DATE.** This section is effective July 1, 2011.

160.8 Sec. 9. **[254B.11] MAXIMUM RATES.**

160.9 The commissioner shall publish maximum rates for vendors of the consolidated
160.10 chemical dependency treatment fund by July 1 of each year for implementation the
160.11 following January 1. Rates for calendar year 2010 must not exceed 185 percent of the
160.12 average rate on January 1, 2009, for each group of vendors with similar attributes. Unless
160.13 a new rate methodology is developed under section 254B.12, rates for services provided on
160.14 and after July 1, 2011, must not exceed 160 percent of the average rate on January 1, 2009,
160.15 for each group of vendors with similar attributes. Payment for services provided by Indian
160.16 Health Services or by agencies operated by Indian tribes for medical assistance-eligible
160.17 individuals must be governed by the applicable federal rate methodology.

160.18 Sec. 10. **[254B.12] RATE METHODOLOGY.**

160.19 (a) The commissioner shall, with broad-based stakeholder input, develop a
160.20 recommendation and present a report to the 2011 legislature, including proposed
160.21 legislation for a new rate methodology for the consolidated chemical dependency
160.22 treatment fund. The new methodology must replace county-negotiated rates with a
160.23 uniform statewide methodology that must include:
160.24 (1) a graduated reimbursement scale based on the patients' level of acuity and
160.25 complexity; and
160.26 (2) beginning July 1, 2012, retroactive quality incentive payments up to four percent
160.27 of each provider's prior-year approved chemical dependency fund claims.
160.28 (b) The quality incentive payments under paragraph (a), clause (2), must be based on
160.29 each provider's performance in the prior year relating to certain program criteria, based on
160.30 best practices in addiction treatment. The quality incentive criteria under paragraph (a),
160.31 clause (2), may include program completion rates, national outcome measures, program
160.32 innovations, lack of licensing violations, and other measures to be determined by the
160.33 commissioner.

161.1 Sec. 11. Minnesota Statutes 2008, section 256B.0625, subdivision 41, is amended to
161.2 read:

161.3 Subd. 41. **Residential services for children with severe emotional disturbance.**
161.4 Medical assistance covers rehabilitative services in accordance with section 256B.0945
161.5 that are provided by a ~~county through a~~ residential facility under contract with a county or
161.6 Indian tribe, for children who have been diagnosed with severe emotional disturbance and
161.7 have been determined to require the level of care provided in a residential facility.

161.8 Sec. 12. Minnesota Statutes 2008, section 256B.0625, subdivision 47, is amended to
161.9 read:

161.10 Subd. 47. **Treatment foster care services.** Effective July 1, ~~2007~~ 2011, and subject
161.11 to federal approval, medical assistance covers treatment foster care services according to
161.12 section 256B.0946.

161.13 Sec. 13. Minnesota Statutes 2008, section 256B.0944, is amended by adding a
161.14 subdivision to read:

161.15 Subd. 4a. **Alternative provider standards.** If a provider entity demonstrates that,
161.16 due to geographic or other barriers, it is not feasible to provide mobile crisis intervention
161.17 services 24 hours a day, seven days a week, according to the standards in subdivision 4,
161.18 paragraph (b), clause (1), the commissioner may approve a crisis response provider based
161.19 on an alternative plan proposed by a provider entity. The alternative plan must:

161.20 (1) result in increased access and a reduction in disparities in the availability of
161.21 crisis services; and

161.22 (2) provide mobile services outside of the usual nine-to-five office hours and on
161.23 weekends and holidays.

161.24 Sec. 14. Minnesota Statutes 2008, section 256B.0945, subdivision 4, is amended to
161.25 read:

161.26 Subd. 4. **Payment rates.** (a) Notwithstanding sections 256B.19 and 256B.041,
161.27 payments to counties for residential services provided by a residential facility shall only
161.28 be made of federal earnings for services provided under this section, and the nonfederal
161.29 share of costs for services provided under this section shall be paid by the county from
161.30 sources other than federal funds or funds used to match other federal funds. Payment to
161.31 counties for services provided according to this section shall be a proportion of the per
161.32 day contract rate that relates to rehabilitative mental health services and shall not include
161.33 payment for costs or services that are billed to the IV-E program as room and board.

~~(b) Per diem rates paid to providers under this section by prepaid plans shall be the proportion of the per-day contract rate that relates to rehabilitative mental health services and shall not include payment for group foster care costs or services that are billed to the county of financial responsibility.~~

~~(c)~~ (b) The commissioner shall set aside a portion not to exceed five percent of the federal funds earned for county expenditures under this section to cover the state costs of administering this section. Any unexpended funds from the set-aside shall be distributed to the counties in proportion to their earnings under this section.

(c) The payment rate negotiated and paid to a provider by prepaid health plans under section 256B.69 for services under this section must be supplemented by the commissioner from state appropriations to cover the nontreatment costs at a rate equal to the portion of the county negotiated per diem attributable to nontreatment service costs for that provider as determined by the commissioner of human services.

(d) Payment for mental health rehabilitative services provided under this section by or under contract with an Indian tribe or tribal organization or by agencies operated by or under contract with an Indian tribe or tribal organization may be made according to section 256B.0625, subdivision 34, or other relevant federally approved rate setting methodology.

Sec. 15. Minnesota Statutes 2008, section 256B.0947, subdivision 1, is amended to read:

Subdivision 1. **Scope.** ~~Subject to federal approval~~ Effective November 1, 2010, and subject to federal approval, medical assistance covers medically necessary, intensive nonresidential rehabilitative mental health services as defined in subdivision 2, for recipients as defined in subdivision 3, when the services are provided by an entity meeting the standards in this section.

Sec. 16. Minnesota Statutes 2008, section 256B.761, is amended to read:

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

(a) Effective for services rendered on or after July 1, 2001, payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.

(b) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates: (1) a Medicare-certified comprehensive outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1,

163.1 1993, with at least 33 percent of the clients receiving rehabilitation services in the most
163.2 recent calendar year who are medical assistance recipients, will be increased by 38 percent,
163.3 when those services are provided within the comprehensive outpatient rehabilitation
163.4 facility and provided to residents of nursing facilities owned by the entity.
163.5 (c) Effective January 1, 2010, the rate for partial hospitalization for children is
163.6 increased to equal the rate for partial hospitalization for adults.

163.7 Sec. 17. **AUTISM SPECTRUM DISORDER JOINT TASK FORCE.**
163.8 (a) The Autism Spectrum Disorder Joint Task Force is composed of 25 members,
163.9 appointed as follows:
163.10 (1) two members of the senate, one appointed by the majority leader and one
163.11 appointed by the minority leader;
163.12 (2) two members of the house of representatives, one from the majority party,
163.13 appointed by the speaker of the house, and one from the minority party, appointed by
163.14 the minority leader; and
163.15 (3) 11 public members appointed by the legislature, with regard to geographic
163.16 diversity in the state, with the senate Subcommittee on Committees of the Committee on
163.17 Rules and Administration making the appointments for the senate, and the speaker of the
163.18 house making the appointments for the house:
163.19 (i) three members who are parents of children with autism spectrum disorder (ASD),
163.20 two of whom shall be appointed by the senate, and one of whom shall be appointed by
163.21 the house;
163.22 (ii) two members who have ASD, one of whom shall be appointed by the senate, and
163.23 one by the house;
163.24 (iii) one member representing an agency that provides residential housing services to
163.25 individuals with ASD, appointed by the house;
163.26 (iv) one member representing an agency that provides employment services to
163.27 individuals with ASD, appointed by the senate;
163.28 (v) one member who is a behavior analyst, appointed by the house;
163.29 (vi) two members who are providers of ASD therapy, with one member appointed
163.30 by the senate and one member appointed by the house; and
163.31 (vii) one member who is a director of public school student support services;
163.32 (4) two members appointed by the Minnesota chapter of the American Academy
163.33 of Pediatrics, one who is a developmental behavioral pediatrician and one who is a
163.34 general pediatrician;

164.1 (5) one member appointed by the Minnesota Psychological Society who is a
164.2 neuropsychologist;
164.3 (6) one member appointed by the Association of Minnesota Counties;
164.4 (7) one member appointed by the Minnesota Association of School Administrators;
164.5 (8) one member appointed by the Somali American Autism Foundation;
164.6 (9) one member appointed by the ARC of Minnesota;
164.7 (10) one member appointed by the Autism Society of Minnesota;
164.8 (11) one member appointed by the Parent Advocacy Coalition for Educational
164.9 Rights; and
164.10 (12) one member appointed by the Minnesota Council of Health Plans.
164.11 Appointments must be made by September 1, 2009. The Legislative Coordinating
164.12 Commission shall provide meeting space for the task force. The senate member appointed
164.13 by the minority leader of the senate shall convene the first meeting of the task force no
164.14 later than October 1, 2009. The task force shall elect a chair from among the public
164.15 members at the first meeting.
164.16 (b) The commissioners of education, employment and economic development,
164.17 health, and human services shall provide assistance to the task force, including providing
164.18 the task force with a count of children who have ASD with an individual education
164.19 program or an individual family service plan and children with ASD who have a 504 plan.
164.20 Additionally, the commissioner of human services shall submit a count of the adults with
164.21 ASD enrolled in social service programs and the number of individuals with ASD who are
164.22 enrolled in medical assistance and other waiver programs.
164.23 (c) The task force shall develop recommendations and report on the following topics:
164.24 (1) ways to improve services provided by all state and political subdivisions;
164.25 (2) sources of public and private funding available for treatment and ways to
164.26 improve efficiency in the use of these funds;
164.27 (3) methods to improve coordination in the delivery of service between public and
164.28 private agencies, health providers, and schools;
164.29 (4) increasing the availability of and the training for medical providers and educators
164.30 who identify and provide services to individuals with ASD;
164.31 (5) ways to enhance Minnesota's role in ASD research and delivery of service;
164.32 (6) methods to educate parents, family members, and the public on ASD and the
164.33 available services; and
164.34 (7) treatment options supported by peer-reviewed, established scientific research
164.35 for individuals with ASD.

165.1 (d) The task force shall coordinate with existing efforts at the Departments of
165.2 Education, Health, Human Services, and Employment and Economic Development
165.3 related to ASD.
165.4 (e) By January 15 of each year, the task force shall provide a report regarding its
165.5 findings and consideration of the topics listed under paragraph (c), and the action taken
165.6 under paragraph (d), including draft legislation if necessary, to the chairs and ranking
165.7 minority members of the legislative committees with jurisdiction over health and human
165.8 services.

165.9 **EFFECTIVE DATE.** This section is effective July 1, 2009, and expires June 30,
165.10 2011.

165.11 Sec. 18. **LAND SALE; MORATORIUM.**
165.12 Surplus land surrounding the Anoka-Metro Regional Treatment Center must not be
165.13 sold for five years.

165.14 **EFFECTIVE DATE.** This section is effective the day following final enactment.

165.15 Sec. 19. **STATE-COUNTY CHEMICAL HEALTH CARE HOME PILOT**
165.16 **PROJECT.**
165.17 Subdivision 1. **Establishment; purpose.** There is established a state-county
165.18 chemical health care home pilot project. The purpose of the pilot project is for the
165.19 Department of Human Services and counties to work in partnership to redesign the current
165.20 chemical health delivery system to promote greater accountability, productivity, and
165.21 results in the delivery of state chemical dependency services. The pilot project must look
165.22 to promote appropriate flexibility in a way that better aligns systems and services to offer
165.23 the most appropriate level of chemical health care services to the client. This may include,
165.24 but is not limited to, developing new governance agreements, performance agreements,
165.25 or service level agreements. The pilot projects must maintain eligibility levels under the
165.26 current programmatic entitlement structure, continue to meet the requirements of Rule 25
165.27 and Rule 31, and must not put at risk current and future federal funding toward chemical
165.28 health-related services in Minnesota.
165.29 Subd. 2. **Work group.** A work group must be convened on or before July 1, 2009,
165.30 consisting of representatives from the Department of Human Services and participating
165.31 counties to develop final proposals for pilot projects meeting the requirements of this
165.32 section. This work group must focus its efforts on the need for systems change, mandate
165.33 and waiver relief, payment reform or other funding options, and outcomes. The work

166.1 group must report back to the legislative committees having jurisdiction over chemical
166.2 health by January 15, 2010, for final approval of pilot projects to be implemented starting
166.3 July 10, 2010.

166.4 Subd. 3. **Report.** The Department of Human Services shall report back to the
166.5 legislative committees having jurisdiction over chemical health by January 15, 2011,
166.6 evaluating the effectiveness of pilot projects, including recommendations for how to
166.7 implement the pilot projects on a statewide basis.

166.8 Subd. 4. **Expiration.** These pilot projects expire ......

166.9 **EFFECTIVE DATE.** This section is effective the day following final enactment.

166.10 **ARTICLE 9**

166.11 **CONTINUING CARE**

166.12 Section 1. Minnesota Statutes 2008, section 144.0724, subdivision 2, is amended to
166.13 read:

166.14 Subd. 2. **Definitions.** For purposes of this section, the following terms have the
166.15 meanings given.

166.16 (a) "Assessment reference date" means the last day of the minimum data set
166.17 observation period. The date sets the designated endpoint of the common observation
166.18 period, and all minimum data set items refer back in time from that point.

166.19 (b) "Case mix index" means the weighting factors assigned to the RUG-III
166.20 classifications.

166.21 (c) "Index maximization" means classifying a resident who could be assigned to
166.22 more than one category, to the category with the highest case mix index.

166.23 (d) "Minimum data set" means the assessment instrument specified by the Centers for
166.24 Medicare and Medicaid Services and designated by the Minnesota Department of Health.

166.25 (e) "Representative" means a person who is the resident's guardian or conservator,
166.26 the person authorized to pay the nursing home expenses of the resident, a representative
166.27 of the nursing home ombudsman's office whose assistance has been requested, or any
166.28 other individual designated by the resident.

166.29 (f) "Resource utilization groups" or "RUG" means the system for grouping a nursing
166.30 facility's residents according to their clinical and functional status identified in data
166.31 supplied by the facility's minimum data set.

166.32 (g) "Activities of daily living" means grooming, dressing, bathing, transferring,
166.33 mobility, positioning, eating, and toileting.

167.1 (h) "Nursing facility level of care determination" means the assessment process
167.2 that results in a determination of a resident's or prospective resident's need for nursing
167.3 facility level of care as established in subdivision 11 for purposes of medical assistance
167.4 payment of long-term care services for:
167.5 (1) nursing facility services under section 256B.434 or 256B.441;
167.6 (2) elderly waiver services under section 256B.0915;
167.7 (3) CADI and TBI waiver services under section 256B.49; and
167.8 (4) state payment of alternative care services under section 256B.0913.

167.9 **EFFECTIVE DATE.** The section is effective July 1, 2011.

167.10 Sec. 2. Minnesota Statutes 2008, section 144.0724, subdivision 4, is amended to read:
167.11 Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and
167.12 electronically submit to the commissioner of health case mix assessments that conform
167.13 with the assessment schedule defined by Code of Federal Regulations, title 42, section
167.14 483.20, and published by the United States Department of Health and Human Services,
167.15 Centers for Medicare and Medicaid Services, in the Long Term Care Assessment
167.16 Instrument User's Manual, version 2.0, October 1995, and subsequent clarifications made
167.17 in the Long-Term Care Assessment Instrument Questions and Answers, version 2.0,
167.18 August 1996. The commissioner of health may substitute successor manuals or question
167.19 and answer documents published by the United States Department of Health and Human
167.20 Services, Centers for Medicare and Medicaid Services, to replace or supplement the
167.21 current version of the manual or document.
167.22 (b) The assessments used to determine a case mix classification for reimbursement
167.23 include the following:
167.24 (1) a new admission assessment must be completed by day 14 following admission;
167.25 (2) an annual assessment must be completed within 366 days of the last
167.26 comprehensive assessment;
167.27 (3) a significant change assessment must be completed within 14 days of the
167.28 identification of a significant change; and
167.29 (4) the second quarterly assessment following either a new admission assessment,
167.30 an annual assessment, or a significant change assessment, and all quarterly assessments
167.31 beginning October 1, 2006. Each quarterly assessment must be completed within 92
167.32 days of the previous assessment.
167.33 (c) In addition to the assessments listed in paragraph (b), the assessments used to
167.34 determine nursing facility level of care include the following:

168.1 (1) preadmission screening completed under section 256B.0911, subdivision 4a,
168.2 by a county, tribe, or managed care organization under contract with the Department
168.3 of Human Services; and
168.4 (2) a face-to-face long-term care consultation assessment completed under section
168.5 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or managed care organization
168.6 under contract with the Department of Human Services.

168.7 **EFFECTIVE DATE.** The section is effective July 1, 2011.

168.8 Sec. 3. Minnesota Statutes 2008, section 144.0724, subdivision 8, is amended to read:
168.9 Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident,
168.10 or resident's representative, or the nursing facility or boarding care home may request that
168.11 the commissioner of health reconsider the assigned reimbursement classification. The
168.12 request for reconsideration must be submitted in writing to the commissioner within
168.13 30 days of the day the resident or the resident's representative receives the resident
168.14 classification notice. The request for reconsideration must include the name of the
168.15 resident, the name and address of the facility in which the resident resides, the reasons for
168.16 the reconsideration, the requested classification changes, and documentation supporting
168.17 the requested classification. The documentation accompanying the reconsideration request
168.18 is limited to documentation which establishes that the needs of the resident at the time of
168.19 the assessment justify a classification which is different than the classification established
168.20 by the commissioner of health.
168.21 (b) Upon request, the nursing facility must give the resident or the resident's
168.22 representative a copy of the assessment form and the other documentation that was given
168.23 to the commissioner of health to support the assessment findings. The nursing facility
168.24 shall also provide access to and a copy of other information from the resident's record that
168.25 has been requested by or on behalf of the resident to support a resident's reconsideration
168.26 request. A copy of any requested material must be provided within three working days of
168.27 receipt of a written request for the information. If a facility fails to provide the material
168.28 within this time, it is subject to the issuance of a correction order and penalty assessment
168.29 under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order
168.30 issued under this subdivision must require that the nursing facility immediately comply
168.31 with the request for information and that as of the date of the issuance of the correction
168.32 order, the facility shall forfeit to the state a $100 fine for the first day of noncompliance, and
168.33 an increase in the $100 fine by $50 increments for each day the noncompliance continues.
168.34 (c) In addition to the information required under paragraphs (a) and (b), a
168.35 reconsideration request from a nursing facility must contain the following information: (i)

169.1 the date the reimbursement classification notices were received by the facility; (ii) the date
169.2 the classification notices were distributed to the resident or the resident's representative;
169.3 and (iii) a copy of a notice sent to the resident or to the resident's representative. This
169.4 notice must inform the resident or the resident's representative that a reconsideration of the
169.5 resident's classification is being requested, the reason for the request, that the resident's
169.6 rate will change if the request is approved by the commissioner, the extent of the change,
169.7 that copies of the facility's request and supporting documentation are available for review,
169.8 and that the resident also has the right to request a reconsideration. If the facility fails to
169.9 provide the required information with the reconsideration request, the request must be
169.10 denied, and the facility may not make further reconsideration requests on that specific
169.11 reimbursement classification.

169.12 (d) Reconsideration by the commissioner must be made by individuals not involved
169.13 in reviewing the assessment, audit, or reconsideration that established the disputed
169.14 classification. The reconsideration must be based upon the initial assessment and upon the
169.15 information provided to the commissioner under paragraphs (a) and (b). If necessary for
169.16 evaluating the reconsideration request, the commissioner may conduct on-site reviews.
169.17 Within 15 working days of receiving the request for reconsideration, the commissioner
169.18 shall affirm or modify the original resident classification. The original classification
169.19 must be modified if the commissioner determines that the assessment resulting in the
169.20 classification did not accurately reflect the needs or assessment characteristics of the
169.21 resident at the time of the assessment. The resident and the nursing facility or boarding
169.22 care home shall be notified within five working days after the decision is made. A decision
169.23 by the commissioner under this subdivision is the final administrative decision of the
169.24 agency for the party requesting reconsideration.

169.25 (e) The resident classification established by the commissioner shall be the
169.26 classification that applies to the resident while the request for reconsideration is pending.
169.27 If a request for reconsideration applies to an assessment used to determine nursing facility
169.28 level of care under subdivision 4, paragraph (c), the resident shall continue to be eligible
169.29 for nursing facility level of care while the request for reconsideration is pending.

169.30 (f) The commissioner may request additional documentation regarding a
169.31 reconsideration necessary to make an accurate reconsideration determination.

169.32 **EFFECTIVE DATE.** The section is effective July 1, 2011.

169.33 Sec. 4. Minnesota Statutes 2008, section 144.0724, is amended by adding a subdivision
169.34 to read:

170.1 Subd. 11. **Nursing facility level of care.** (a) For purposes of medical assistance
170.2 payment of long-term care services, a recipient must be determined, using assessments
170.3 defined in subdivision 4, to meet one of the following nursing facility level of care criteria:
170.4 (1) the person needs the assistance of another person or constant supervision to begin
170.5 and complete at least four of the following activities of living: bathing, bed mobility,
170.6 dressing, eating, grooming, toileting, transferring, and walking;
170.7 (2) the person needs the assistance of another person or constant supervision to begin
170.8 and complete toileting, transferring, or positioning and the assistance cannot be scheduled;
170.9 (3) the person has significant difficulty with memory, using information, daily
170.10 decision making, or behavioral needs that require intervention;
170.11 (4) the person has had a qualifying nursing facility stay of at least 90 days; or
170.12 (5) the person is determined to be at risk for nursing facility admission or
170.13 readmission through a face-to-face long-term care consultation assessment as specified
170.14 in section 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or managed care
170.15 organization under contract with the Department of Human Services. The person is
170.16 considered at risk under this clause if the person currently lives alone or will live alone
170.17 upon discharge and also meets one of the following criteria:
170.18 (i) the person has experienced a fall resulting in a fracture;
170.19 (ii) the person has been determined to be at risk of maltreatment or neglect,
170.20 including self-neglect; or
170.21 (iii) the person has a sensory impairment that substantially impacts functional ability
170.22 and maintenance of a community residence.
170.23 (b) The assessment used to establish medical assistance payment for nursing facility
170.24 services must be the most recent assessment performed under subdivision 4, paragraph
170.25 (b), that occurred no more than 90 calendar days before the effective date of medical
170.26 assistance eligibility for payment of long-term care services. In no case shall medical
170.27 assistance payment for long-term care services occur prior to the date of the determination
170.28 of nursing facility level of care.
170.29 (c) The assessment used to establish medical assistance payment for long-term care
170.30 services provided under sections 256B.0915 and 256B.49 and alternative care payment
170.31 for services provided under section 256B.0913 must be the most recent face-to-face
170.32 assessment performed under subdivision 4, paragraph (c), clause (2), that occurred no
170.33 more than 60 calendar days before the effective date of medical assistance eligibility
170.34 for payment of long-term care services.

170.35 **EFFECTIVE DATE.** The section is effective July 1, 2011.

171.1 Sec. 5. Minnesota Statutes 2008, section 144.0724, is amended by adding a subdivision
171.2 to read:
171.3 Subd. 12. **Appeal of nursing facility level of care determination.** A resident or
171.4 prospective resident whose level of care determination results in a denial of long-term care
171.5 services can appeal the determination as outlined in section 256B.0911, subdivision 3a,
171.6 paragraph (h), clause (7).

171.7 **EFFECTIVE DATE.** The section is effective July 1, 2011.

171.8 Sec. 6. Minnesota Statutes 2008, section 144A.073, is amended by adding a
171.9 subdivision to read:
171.10 Subd. 12. **Extension of approval of moratorium exception projects.**
171.11 Notwithstanding subdivision 3, the commissioner of health shall extend project approval
171.12 by an additional 18 months for an approved proposal for an exception to the nursing home
171.13 licensure and certification moratorium if the proposal was approved under this section
171.14 between July 1, 2007, and June 30, 2009.

171.15 Sec. 7. Minnesota Statutes 2008, section 144A.44, subdivision 2, is amended to read:
171.16 Subd. 2. **Interpretation and enforcement of rights.** These rights are established
171.17 for the benefit of persons who receive home care services. "Home care services" means
171.18 home care services as defined in section 144A.43, subdivision 3, and unlicensed personal
171.19 care assistance services, including services covered by medical assistance under section
171.20 256B.0625, subdivision 19a. A home care provider may not require a person to surrender
171.21 these rights as a condition of receiving services. A guardian or conservator or, when there
171.22 is no guardian or conservator, a designated person, may seek to enforce these rights. This
171.23 statement of rights does not replace or diminish other rights and liberties that may exist
171.24 relative to persons receiving home care services, persons providing home care services, or
171.25 providers licensed under Laws 1987, chapter 378. A copy of these rights must be provided
171.26 to an individual at the time home care services, including personal care assistance
171.27 services, are initiated. The copy shall also contain the address and phone number of the
171.28 Office of Health Facility Complaints and the Office of Ombudsman for Long-Term Care
171.29 and a brief statement describing how to file a complaint with these offices. Information
171.30 about how to contact the Office of Ombudsman for Long-Term Care shall be included in
171.31 notices of change in client fees and in notices where home care providers initiate transfer
171.32 or discontinuation of services.

172.1 Sec. 8. Minnesota Statutes 2008, section 245A.03, is amended by adding a subdivision
172.2 to read:
172.3 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an
172.4 initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to
172.5 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to
172.6 9555.6265, under this chapter for a physical location that will not be the primary residence
172.7 of the license holder for the entire period of licensure. If a license is issued during this
172.8 moratorium, and the license holder changes the license holder's primary residence away
172.9 from the physical location of the foster care license, the commissioner shall revoke the
172.10 license according to section 245A.07. Exceptions to the moratorium include:
172.11 (1) foster care settings that are required to be registered under chapter 144D;
172.12 (2) foster care licenses replacing foster care licenses in existence on the effective
172.13 date of this section and determined to be needed by the commissioner under paragraph (b);
172.14 (3) new foster care licenses determined to be needed by the commissioner under
172.15 paragraph (b) for the closure of a nursing facility, ICF/MR, or regional treatment center;
172.16 (4) new foster care licenses determined to be needed by the commissioner under
172.17 paragraph (b) for persons requiring hospital level of care;
172.18 (5) new foster care licenses determined to be needed by the commissioner for the
172.19 transition of people from personal care assistance to the home and community-based
172.20 services; or
172.21 (6) new foster care residences in development that have received county approval
172.22 prior to July 1, 2011, but may not have received a license from the commissioner for
172.23 the actual residence.
172.24 (b) The commissioner shall determine the need for newly licensed foster care homes
172.25 as defined under this subdivision. As part of the determination, the commissioner shall
172.26 consider the availability of foster care capacity in the area which the licensee seeks to
172.27 operate, and the recommendation of the local county board. The determination by the
172.28 commissioner must be final. A determination of need is not required for a change in
172.29 ownership at the same address.
172.30 (c) Residential settings that would otherwise fall under the moratorium established in
172.31 paragraph (a), that are in the process of receiving an adult or child foster care license as of
172.32 July 1, 2011, must be able to continue to complete the process of receiving an adult or child
172.33 foster care license. For purposes of this paragraph, all of the following conditions must be
172.34 met to be considered in the process of receiving an adult or child foster care license:
172.35 (1) participants have made decisions to move into the residential setting, including
172.36 documentation in each participant's care plans;

173.1 (2) the provider has purchased housing or has made a financial investment in the
173.2 property;
173.3 (3) the lead agency has approved the plans, including costs for the residential setting
173.4 for each individual;
173.5 (4) the completion of the licensing process, including all necessary inspections, is
173.6 the only remaining component prior to being able to provide services; and
173.7 (5) the needs of the individuals cannot be met within the existing capacity in that
173.8 county.

173.9 To qualify for the process under this paragraph, the lead agency must submit
173.10 documentation to the commissioner by August 1, 2011, that all of the criteria in this
173.11 paragraph are met.
173.12 (d) The commissioner shall study the effects of the license moratorium under this
173.13 subdivision and shall report back to the legislature by January 15, 2013.

173.14 **EFFECTIVE DATE.** This section is effective July 1, 2011.

173.15 Sec. 9. Minnesota Statutes 2008, section 245A.11, is amended by adding a subdivision
173.16 to read:
173.17 Subd. 8. **Community residential setting license.** (a) The commissioner shall
173.18 establish provider standards for residential support services that integrate service standards
173.19 and the residential setting under one license. The commissioner shall propose statutory
173.20 language and an implementation plan for licensing requirements for residential support
173.21 services to the legislature by January 15, 2011.
173.22 (b) Providers licensed under chapter 245B, and providing, contracting, or arranging
173.23 for services in settings licensed as adult foster care under Minnesota Rules, parts
173.24 9555.5105 to 9555.6265, or child foster care under Minnesota Rules, parts 2960.3000 to
173.25 2960.3340; and meeting the provisions of section 256B.092, subdivision 11, paragraph
173.26 (b), must be required to obtain a community residential setting license.

173.27 Sec. 10. Minnesota Statutes 2008, section 252.46, is amended by adding a subdivision
173.28 to read:
173.29 Subd. 1a. **Day training and habilitation rates.** The commissioner shall establish
173.30 a statewide rate-setting methodology for all day training and habilitation services. The
173.31 rate-setting methodology must abide by the principles of transparency and equitability
173.32 across the state. The methodology must involve a uniform process of structuring rates for
173.33 each service and must promote quality and participant choice.

174.1 Sec. 11. Minnesota Statutes 2008, section 252.50, subdivision 1, is amended to read:
174.2 Subdivision 1. **Community-based programs established.** The commissioner
174.3 shall establish a system of state-operated, community-based programs for persons with
174.4 developmental disabilities. For purposes of this section, "state-operated, community-based
174.5 program" means a program administered by the state to provide treatment and habilitation
174.6 in noninstitutional community settings to persons with developmental disabilities.
174.7 Employees of the programs, except clients who work within and benefit from these
174.8 treatment and habilitation programs, must be state employees under chapters 43A and
174.9 179A. Although any clients who work within and benefit from these treatment and
174.10 habilitation programs are not employees under chapters 43A and 179A, the Department
174.11 of Human Services may consider clients who work within and benefit from these
174.12 programs employees for federal tax purposes. The establishment of state-operated,
174.13 community-based programs must be within the context of a comprehensive definition of
174.14 the role of state-operated services in the state. The role of state-operated services must
174.15 be defined within the context of a comprehensive system of services for persons with
174.16 developmental disabilities. State-operated, community-based programs may include, but
174.17 are not limited to, community group homes, foster care, supportive living services, day
174.18 training and habilitation programs, and respite care arrangements. The commissioner
174.19 may operate the pilot projects established under Laws 1985, First Special Session
174.20 chapter 9, article 1, section 2, subdivision 6, and shall, within the limits of available
174.21 appropriations, establish additional state-operated, community-based programs for
174.22 persons with developmental disabilities. State-operated, community-based programs may
174.23 accept admissions from regional treatment centers, from the person's own home, or from
174.24 community programs. State-operated, community-based programs offering day program
174.25 services may be provided for persons with developmental disabilities who are living in
174.26 state-operated, community-based residential programs until July 1, 2000. No later than
174.27 1994, the commissioner, together with family members, counties, advocates, employee
174.28 representatives, and other interested parties, shall begin planning so that by July 1, 2000,
174.29 state-operated, community-based residential facilities will be in compliance with section
174.30 252.41, subdivision 9.

174.31 Sec. 12. Minnesota Statutes 2008, section 256.01, is amended by adding a subdivision
174.32 to read:
174.33 Subd. 29. **State medical review team.** (a) To ensure the timely processing of
174.34 determinations of disability by the commissioner's state medical review team under
174.35 sections 256B.055, subdivision 7, paragraph (b), and 256B.057, subdivision 9, paragraph

175.1 (j), the commissioner shall review all medical evidence submitted by county agencies with
175.2 a referral and seek additional information from providers, applicants, and enrollees to
175.3 support the determination of disability where necessary.

175.4 (b) Prior to a denial or withdrawal of a requested determination of disability due
175.5 to insufficient evidence, the commissioner shall (1) ensure that the missing evidence is
175.6 necessary and appropriate to a determination of disability, and (2) assist applicants and
175.7 enrollees to obtain the evidence, including, but not limited to, medical examinations
175.8 and electronic medical records.

175.9 (c) The commissioner shall provide the chairs of the legislative committees with
175.10 jurisdiction over health and human services finance and budget the following information
175.11 on the activities of the state medical review team by February 1, 2010, and annually
175.12 thereafter:

175.13 (1) the number of applications to the state medical review team that were denied,
175.14 approved, or withdrawn;

175.15 (2) the average length of time from receipt of the application to a decision;

175.16 (3) the number of appeals and appeal results;

175.17 (4) for applicants, their age, health coverage at the time of application, hospitalization
175.18 history within three months of application, and whether an application for Social Security
175.19 or Supplemental Security Income benefits is pending; and

175.20 (5) specific information on the medical certification, licensure, or other credentials
175.21 of the person or persons performing the medical review determinations and length of
175.22 time in that position.

175.23 Sec. 13. **[256.0281] INTERAGENCY DATA EXCHANGE.**

175.24 The Department of Human Services, the Department of Health, and the Office of the
175.25 Ombudsman for Mental Health and Developmental Disabilities may establish interagency
175.26 agreements governing the electronic exchange of data on providers and individuals
175.27 collected, maintained, or used by each agency when such exchange is outlined by each
175.28 agency in an interagency agreement to accomplish the purposes in clauses (1) to (4):

175.29 (1) to improve provider enrollment processes for home and community-based
175.30 services and state plan home care services;

175.31 (2) to improve quality management of providers between state agencies;

175.32 (3) to establish and maintain provider eligibility to participate as providers under
175.33 Minnesota health care programs; and

176.1 (4) to meet the quality assurance reporting requirements under federal law under
176.2 section 1915(c) of the Social Security Act related to home and community-based waiver
176.3 programs.

176.4 Each interagency agreement must include provisions to ensure anonymity of individuals,
176.5 including mandated reporters, and must outline the specific uses of and access to shared
176.6 data within each agency. Electronic interfaces between source data systems developed
176.7 under these interagency agreements must incorporate these provisions as well as other
176.8 HIPPA provisions related to individual data.

176.9 Sec. 14. Minnesota Statutes 2008, section 256.476, subdivision 5, is amended to read:

176.10 Subd. 5. **Reimbursement, allocations, and reporting.** (a) For the purpose of
176.11 transferring persons to the consumer support grant program from the family support
176.12 program and personal care assistant services, home health aide services, or private duty
176.13 nursing services, the amount of funds transferred by the commissioner between the
176.14 family support program account, the medical assistance account, or the consumer support
176.15 grant account shall be based on each county's participation in transferring persons to the
176.16 consumer support grant program from those programs and services.

176.17 (b) At the beginning of each fiscal year, county allocations for consumer support
176.18 grants shall be based on:

176.19 (1) the number of persons to whom the county board expects to provide consumer
176.20 supports grants;

176.21 (2) their eligibility for current program and services;

176.22 (3) the ~~amount of nonfederal dollars~~ monthly grant levels allowed under subdivision
176.23 11; and

176.24 (4) projected dates when persons will start receiving grants. County allocations shall
176.25 be adjusted periodically by the commissioner based on the actual transfer of persons or
176.26 service openings, and the ~~nonfederal dollars~~ monthly grant levels associated with those
176.27 persons or service openings, to the consumer support grant program.

176.28 (c) The amount of funds transferred by the commissioner from the medical
176.29 assistance account for an individual may be changed if it is determined by the county or its
176.30 agent that the individual's need for support has changed.

176.31 (d) The authority to utilize funds transferred to the consumer support grant account
176.32 for the purposes of implementing and administering the consumer support grant program
176.33 will not be limited or constrained by the spending authority provided to the program
176.34 of origination.

(e) The commissioner may use up to five percent of each county's allocation, as adjusted, for payments for administrative expenses, to be paid as a proportionate addition to reported direct service expenditures.

(f) The county allocation for each person or the person's legal representative or other authorized representative cannot exceed the amount allowed under subdivision 11.

(g) The commissioner may recover, suspend, or withhold payments if the county board, local agency, or grantee does not comply with the requirements of this section.

(h) Grant funds unexpended by consumers shall return to the state once a year. The annual return of unexpended grant funds shall occur in the quarter following the end of the state fiscal year.

Sec. 15. Minnesota Statutes 2008, section 256.476, subdivision 11, is amended to read:

Subd. 11. **Consumer support grant program after July 1, 2001.** ~~(a)~~ Effective July 1, 2001, the commissioner shall allocate consumer support grant resources to serve additional individuals based on a review of Medicaid authorization and payment information of persons eligible for a consumer support grant from the most recent fiscal year. The commissioner shall use the following methodology to calculate maximum allowable monthly consumer support grant levels:

(1) For individuals whose program of origination is medical assistance home care under sections 256B.0651 and 256B.0653 to 256B.0656, the maximum allowable monthly grant levels are calculated by:

(i) determining ~~the nonfederal share~~ 50 percent of the average service authorization for each home care rating;

(ii) calculating the overall ratio of actual payments to service authorizations by program;

(iii) applying the overall ratio to the average service authorization level of each home care rating;

(iv) adjusting the result for any authorized rate increases provided by the legislature; and

(v) adjusting the result for the average monthly utilization per recipient.

(2) The commissioner may review and evaluate the methodology to reflect changes in the home care ~~program's overall ratio of actual payments to service authorizations~~ programs.

~~(b) Effective January 1, 2004, persons previously receiving exception grants will have their grants calculated using the methodology in paragraph (a), clause (1). If a person currently receiving an exception grant wishes to have their home care rating reevaluated,~~

178.1 ~~they may request an assessment as defined in section 256B.0651, subdivision 1, paragraph~~
178.2 ~~(b).~~

178.3 Sec. 16. Minnesota Statutes 2008, section 256.975, subdivision 7, is amended to read:
178.4 Subd. 7. **Consumer information and assistance; senior linkage.** (a) The
178.5 Minnesota Board on Aging shall operate a statewide information and assistance service
178.6 to aid older Minnesotans and their families in making informed choices about long-term
178.7 care options and health care benefits. Language services to persons with limited English
178.8 language skills may be made available. The service, known as Senior LinkAge Line, must
178.9 be available during business hours through a statewide toll-free number and must also
178.10 be available through the Internet.
178.11 (b) The service must ~~assist~~ provide long-term care options counseling by assisting
178.12 older adults, caregivers, and providers in accessing information about choices in long-term
178.13 care services that are purchased through private providers or available through public
178.14 options. The service must:
178.15 (1) develop a comprehensive database that includes detailed listings in both
178.16 consumer- and provider-oriented formats;
178.17 (2) make the database accessible on the Internet and through other telecommunication
178.18 and media-related tools;
178.19 (3) link callers to interactive long-term care screening tools and make these tools
178.20 available through the Internet by integrating the tools with the database;
178.21 (4) develop community education materials with a focus on planning for long-term
178.22 care and evaluating independent living, housing, and service options;
178.23 (5) conduct an outreach campaign to assist older adults and their caregivers in
178.24 finding information on the Internet and through other means of communication;
178.25 (6) implement a messaging system for overflow callers and respond to these callers
178.26 by the next business day;
178.27 (7) link callers with county human services and other providers to receive more
178.28 in-depth assistance and consultation related to long-term care options;
178.29 (8) link callers with quality profiles for nursing facilities and other providers
178.30 developed by the commissioner of health; ~~and~~
178.31 (9) incorporate information about housing with services and consumer rights
178.32 within the MinnesotaHelp.info network long-term care database to facilitate consumer
178.33 comparison of services and costs among housing with services establishments and with
178.34 other in-home services and to support financial self-sufficiency as long as possible.
178.35 Housing with services establishments and their arranged home care providers shall provide

179.1 information to the commissioner of human services that is consistent with information
179.2 required by the commissioner of health under section 144G.06, the Uniform Consumer
179.3 Information Guide. The commissioner of human services shall provide the data to the
179.4 Minnesota Board on Aging for inclusion in the MinnesotaHelp.info network long-term
179.5 care database.; and

179.6 (10) provide long-term care options counseling. Long-term care options counselors
179.7 shall:

179.8 (i) for individuals not eligible for case management under a public program or
179.9 public funding source, provide interactive decision support whereby consumers, family
179.10 members, or other helpers are supported in their deliberations to determine appropriate
179.11 long-term care choices in the context of the consumer's needs, preferences, values, and
179.12 individual circumstances including implementing a community support plan;

179.13 (ii) provide Web-based educational information and collateral written materials to
179.14 familiarize consumers, family members, or other helpers with the long-term care basics,
179.15 issues to be considered, and the range of options available in the community;

179.16 (iii) provide long-term care futures planning defined as providing assistance to
179.17 individuals who anticipate having long-term care needs to develop a plan for the more
179.18 distant future; and

179.19 (iv) provide expertise in benefits and financing options for long-term care including
179.20 Medicare, long-term care insurance, tax or employer-based incentives, reverse mortgages,
179.21 private pay options, and ways to access low or no-cost services or benefits through
179.22 volunteer-based or charitable programs.

179.23 (c) The Minnesota Board on Aging shall conduct an evaluation of the effectiveness
179.24 of the statewide information and assistance, and submit this evaluation to the legislature
179.25 by December 1, 2002. The evaluation must include an analysis of funding adequacy, gaps
179.26 in service delivery, continuity in information between the service and identified linkages,
179.27 and potential use of private funding to enhance the service.

179.28 Sec. 17. Minnesota Statutes 2008, section 256B.055, subdivision 7, is amended to read:

179.29 Subd. 7. **Aged, blind, or disabled persons.** (a) Medical assistance may be paid for
179.30 a person who meets the categorical eligibility requirements of the supplemental security
179.31 income program or, who would meet those requirements except for excess income or
179.32 assets, and who meets the other eligibility requirements of this section.

179.33 (b) Following a determination that the applicant is not aged or blind and does not
179.34 meet any other category of eligibility for medical assistance and has not been determined

180.1 disabled by the Social Security Administration, applicants under this subdivision shall be
180.2 referred to the commissioner's state medical review team for a determination of disability.

180.3 Sec. 18. Minnesota Statutes 2008, section 256B.057, subdivision 9, is amended to read:
180.4 Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid
180.5 for a person who is employed and who:
180.6 (1) meets the definition of disabled under the supplemental security income program;
180.7 (2) is at least 16 but less than 65 years of age;
180.8 (3) meets the asset limits in paragraph (c); and
180.9 (4) effective November 1, 2003, pays a premium and other obligations under
180.10 paragraph (e).

180.11 Any spousal income or assets shall be disregarded for purposes of eligibility and premium
180.12 determinations.
180.13 (b) After the month of enrollment, a person enrolled in medical assistance under
180.14 this subdivision who:
180.15 (1) is temporarily unable to work and without receipt of earned income due to a
180.16 medical condition, as verified by a physician, may retain eligibility for up to four calendar
180.17 months; or
180.18 (2) effective January 1, 2004, loses employment for reasons not attributable to the
180.19 enrollee, may retain eligibility for up to four consecutive months after the month of job
180.20 loss. To receive a four-month extension, enrollees must verify the medical condition or
180.21 provide notification of job loss. All other eligibility requirements must be met and the
180.22 enrollee must pay all calculated premium costs for continued eligibility.
180.23 (c) For purposes of determining eligibility under this subdivision, a person's assets
180.24 must not exceed $20,000, excluding:
180.25 (1) all assets excluded under section 256B.056;
180.26 (2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans,
180.27 Keogh plans, and pension plans; and
180.28 (3) medical expense accounts set up through the person's employer.
180.29 (d)(1) Effective January 1, 2004, for purposes of eligibility, there will be a $65
180.30 earned income disregard. To be eligible, a person applying for medical assistance under
180.31 this subdivision must have earned income above the disregard level.
180.32 (2) Effective January 1, 2004, to be considered earned income, Medicare, Social
180.33 Security, and applicable state and federal income taxes must be withheld. To be eligible,
180.34 a person must document earned income tax withholding.

181.1 (e)(1) A person whose earned and unearned income is equal to or greater than 100
181.2 percent of federal poverty guidelines for the applicable family size must pay a premium
181.3 to be eligible for medical assistance under this subdivision. The premium shall be based
181.4 on the person's gross earned and unearned income and the applicable family size using a
181.5 sliding fee scale established by the commissioner, which begins at one percent of income
181.6 at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income
181.7 for those with incomes at or above 300 percent of the federal poverty guidelines. Annual
181.8 adjustments in the premium schedule based upon changes in the federal poverty guidelines
181.9 shall be effective for premiums due in July of each year.

181.10 (2) Effective January 1, 2004, all enrollees must pay a premium to be eligible for
181.11 medical assistance under this subdivision. An enrollee shall pay the greater of a $35
181.12 premium or the premium calculated in clause (1).

181.13 (3) Effective November 1, 2003, all enrollees who receive unearned income must
181.14 pay one-half of one percent of unearned income in addition to the premium amount.

181.15 (4) Effective November 1, 2003, for enrollees whose income does not exceed 200
181.16 percent of the federal poverty guidelines and who are also enrolled in Medicare, the
181.17 commissioner must reimburse the enrollee for Medicare Part B premiums under section
181.18 256B.0625, subdivision 15, paragraph (a).

181.19 (5) Increases in benefits under title II of the Social Security Act shall not be counted
181.20 as income for purposes of this subdivision until July 1 of each year.

181.21 (f) A person's eligibility and premium shall be determined by the local county
181.22 agency. Premiums must be paid to the commissioner. All premiums are dedicated to
181.23 the commissioner.

181.24 (g) Any required premium shall be determined at application and redetermined at
181.25 the enrollee's six-month income review or when a change in income or household size is
181.26 reported. Enrollees must report any change in income or household size within ten days
181.27 of when the change occurs. A decreased premium resulting from a reported change in
181.28 income or household size shall be effective the first day of the next available billing month
181.29 after the change is reported. Except for changes occurring from annual cost-of-living
181.30 increases, a change resulting in an increased premium shall not affect the premium amount
181.31 until the next six-month review.

181.32 (h) Premium payment is due upon notification from the commissioner of the
181.33 premium amount required. Premiums may be paid in installments at the discretion of
181.34 the commissioner.

181.35 (i) Nonpayment of the premium shall result in denial or termination of medical
181.36 assistance unless the person demonstrates good cause for nonpayment. Good cause exists

182.1 if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to
182.2 D, are met. Except when an installment agreement is accepted by the commissioner,
182.3 all persons disenrolled for nonpayment of a premium must pay any past due premiums
182.4 as well as current premiums due prior to being reenrolled. Nonpayment shall include
182.5 payment with a returned, refused, or dishonored instrument. The commissioner may
182.6 require a guaranteed form of payment as the only means to replace a returned, refused,
182.7 or dishonored instrument.

182.8 (j) Following a determination that the applicant is not aged or blind and does not
182.9 meet any other category of eligibility for medical assistance and has not been determined
182.10 disabled by the Social Security Administration, applicants under this subdivision shall be
182.11 referred to the commissioner's state medical review team for a determination of disability.

182.12 Sec. 19. Minnesota Statutes 2008, section 256B.0625, subdivision 7, is amended to
182.13 read:

182.14 Subd. 7. **Private duty nursing.** Medical assistance covers private duty nursing
182.15 services in a recipient's home. Recipients who are authorized to receive private duty
182.16 nursing services in their home may use approved hours outside of the home during hours
182.17 when normal life activities take them outside of their home. To use private duty nursing
182.18 services at school, the recipient or responsible party must provide written authorization in
182.19 the care plan identifying the chosen provider and the daily amount of services to be used at
182.20 school. Medical assistance does not cover private duty nursing services for residents of a
182.21 hospital, nursing facility, intermediate care facility, or a health care facility licensed by the
182.22 commissioner of health, except as authorized in section 256B.64 for ventilator-dependent
182.23 recipients in hospitals or unless a resident who is otherwise eligible is on leave from the
182.24 facility and the facility either pays for the private duty nursing services or forgoes the
182.25 facility per diem for the leave days that private duty nursing services are used. Total
182.26 hours of service and payment allowed for services outside the home cannot exceed
182.27 that which is otherwise allowed in an in-home setting according to sections 256B.0651
182.28 and ~~256B.0653~~ 256B.0654 to 256B.0656. All private duty nursing services must be
182.29 provided according to the limits established under sections 256B.0651 and 256B.0653
182.30 to 256B.0656. Private duty nursing services may not be reimbursed if the nurse is the
182.31 family foster care provider of a recipient who is under age 18 except as allowed under
182.32 section 256B.0659, subdivision 4.

182.33 Sec. 20. Minnesota Statutes 2008, section 256B.0625, subdivision 8, is amended to
182.34 read:

183.1 Subd. 8. **Physical therapy.** Medical assistance covers physical therapy, as
183.2 described in section 148.65, and related services, including specialized maintenance
183.3 therapy. Services provided by a physical therapy assistant shall be reimbursed at the
183.4 same rate as services performed by a physical therapist when the services of the physical
183.5 therapy assistant are provided under the direction of a physical therapist who is on the
183.6 premises. Services provided by a physical therapy assistant that are provided under the
183.7 direction of a physical therapist who is not on the premises shall be reimbursed at 65
183.8 percent of the physical therapist rate.

183.9 Sec. 21. Minnesota Statutes 2008, section 256B.0625, subdivision 8a, is amended to
183.10 read:

183.11 Subd. 8a. **Occupational therapy.** Medical assistance covers occupational therapy,
183.12 as described in section 148.6404, and related services, including specialized maintenance
183.13 therapy. Services provided by an occupational therapy assistant shall be reimbursed at
183.14 the same rate as services performed by an occupational therapist when the services of
183.15 the occupational therapy assistant are provided under the direction of the occupational
183.16 therapist who is on the premises. Services provided by an occupational therapy assistant
183.17 that are provided under the direction of an occupational therapist who is not on the
183.18 premises shall be reimbursed at 65 percent of the occupational therapist rate.

183.19 Sec. 22. Minnesota Statutes 2008, section 256B.0625, subdivision 19a, is amended to
183.20 read:

183.21 Subd. 19a. **Personal care assistant services.** Medical assistance covers personal
183.22 care assistant services in a recipient's home. To qualify for personal care assistant services,
183.23 a recipient must require assistance and be determined dependent in one activity of daily
183.24 living as defined in section 256B.0659 or have a level I behavior as defined in section
183.25 256B.0659. Recipients or responsible parties must be able to identify the recipient's needs,
183.26 direct and evaluate task accomplishment, and provide for health and safety. Approved
183.27 hours may be used outside the home when normal life activities take them outside the
183.28 home. To use personal care assistant services at school, the recipient or responsible party
183.29 must provide written authorization in the care plan identifying the chosen provider and the
183.30 daily amount of services to be used at school. Total hours for services, whether actually
183.31 performed inside or outside the recipient's home, cannot exceed that which is otherwise
183.32 allowed for personal care assistant services in an in-home setting according to sections
183.33 256B.0651 ~~and 256B.0653~~ to 256B.0656. Medical assistance does not cover personal care
183.34 assistant services for residents of a hospital, nursing facility, intermediate care facility,

184.1 health care facility licensed by the commissioner of health, or unless a resident who is
184.2 otherwise eligible is on leave from the facility and the facility either pays for the personal
184.3 care assistant services or forgoes the facility per diem for the leave days that personal care
184.4 assistant services are used. All personal care assistant services must be provided according
184.5 to sections 256B.0651 ~~and 256B.0653~~ to 256B.0656. Personal care assistant services
184.6 may not be reimbursed if the personal care assistant is the spouse or ~~legal~~ paid guardian
184.7 of the recipient or the parent of a recipient under age 18, or the responsible party or the
184.8 foster care provider ~~of a recipient who cannot direct the recipient's own care unless, in the~~
184.9 ~~case of a foster care provider,~~ unless the foster home is the licensed provider's primary
184.10 residence and a county or state case manager visits the recipient as needed, but not less
184.11 than every six months, to monitor the health and safety of the recipient and to ensure the
184.12 goals of the care plan are met. ~~Parents of adult recipients, adult children of the recipient~~
184.13 ~~or adult siblings of the recipient may be reimbursed for personal care assistant services,~~
184.14 ~~if they are granted a waiver under sections 256B.0651 and 256B.0653 to 256B.0656~~.
184.15 Notwithstanding the provisions of section ~~256B.0655, subdivision 2, paragraph (b), clause~~
184.16 ~~(4)~~ 256B.0659, the ~~noncorporate legal~~ unpaid guardian or conservator of an adult, who
184.17 is not the responsible party and not the personal care provider organization, may be
184.18 ~~granted a hardship waiver under sections 256B.0651 and 256B.0653 to 256B.0656, to be~~
184.19 reimbursed to provide personal care assistant services to the recipient if the guardian or
184.20 conservator meet all criteria for a personal care assistant according to section 256B.0659,
184.21 and shall not be considered to have a service provider interest for purposes of participation
184.22 on the screening team under section 256B.092, subdivision 7.

184.23 Sec. 23. Minnesota Statutes 2008, section 256B.0625, subdivision 19c, is amended to
184.24 read:

184.25 Subd. 19c. **Personal care.** (a) Medical assistance covers personal care assistant
184.26 services provided by an individual who is qualified to provide the services according
184.27 to subdivision 19a and sections 256B.0651 ~~and 256B.0653~~ to 256B.0656, ~~where the~~
184.28 ~~services have a statement of need by a physician,~~ provided in accordance with a plan, and
184.29 ~~are~~ supervised by ~~the recipient or~~ a qualified professional. ~~The physician's statement of~~
184.30 ~~need for personal care assistant services shall be documented on a form approved by the~~
184.31 ~~commissioner and include the diagnosis or condition of the person that results in a need~~
184.32 ~~for personal care assistant services and be updated when the person's medical condition~~
184.33 ~~requires a change, but at least annually if the need for personal care assistant services is~~
184.34 ~~ongoing.~~

185.1 (b) "Qualified professional" means a mental health professional as defined in section
185.2 245.462, subdivision 18, or 245.4871, subdivision 27; or a registered nurse as defined in
185.3 sections 148.171 to 148.285, or a licensed social worker as defined in section 148B.21;
185.4 or qualified developmental disabilities professional under section 245B.07, subdivision
185.5 4. As part of the assessment, the county public health nurse will assist the recipient or
185.6 responsible party to identify the most appropriate person to provide supervision of the
185.7 personal care assistant. The qualified professional shall perform the duties described
185.8 required in Minnesota Rules, part 9505.0335, subpart 4 section 256B.0659.

185.9 Sec. 24. Minnesota Statutes 2008, section 256B.0641, subdivision 3, is amended to
185.10 read:

185.11 Subd. 3. **Facility in receivership.** Subdivision 2 does not apply to the change of
185.12 ownership of a facility to a nonrelated organization while the facility to be sold, transferred
185.13 or reorganized is in receivership under section 144A.14, 144A.15, 245A.12, or 245A.13,
185.14 and the commissioner during the receivership has not determined the need to place
185.15 residents of the facility into a newly constructed or newly established facility. Nothing
185.16 in this subdivision limits the liability of a former owner.

185.17 Sec. 25. Minnesota Statutes 2008, section 256B.0651, is amended to read:

185.18 **256B.0651 HOME CARE SERVICES.**

185.19 Subdivision 1. **Definitions.** (a) "Activities of daily living" includes eating, toileting,
185.20 grooming, dressing, bathing, transferring, mobility, and positioning For the purposes of
185.21 sections 256B.0651 to 256B.0656 and 256B.0659, the terms in paragraphs (b) to (g)
185.22 have the meanings given.

185.23 (b) "Activities of daily living" has the meaning given in section 256B.0659,
185.24 subdivision 1, paragraph (b).

185.25 (b) (c) "Assessment" means a review and evaluation of a recipient's need for home
185.26 care services conducted in person. Assessments for home health agency services shall be
185.27 conducted by a home health agency nurse. Assessments for medical assistance home care
185.28 services for developmental disability and alternative care services for developmentally
185.29 disabled home and community-based waivered recipients may be conducted by the county
185.30 public health nurse to ensure coordination and avoid duplication. Assessments must be
185.31 completed on forms provided by the commissioner within 30 days of a request for home
185.32 care services by a recipient or responsible party.

185.33 (c) (d) "Home care services" means a health service, determined by the commissioner
185.34 as medically necessary, that is ordered by a physician and documented in a service plan

186.1 that is reviewed by the physician at least once every 60 days for the provision of home
186.2 health services, or private duty nursing, or at least once every 365 days for personal care.
186.3 Home care services are provided to the recipient at the recipient's residence that is a
186.4 place other than a hospital or long-term care facility or as specified in section 256B.0625
186.5 means medical assistance covered services that are home health agency services, including
186.6 skilled nurse visits; home health aide visits; physical therapy, occupational therapy,
186.7 respiratory therapy, and language-speech pathology therapy; private duty nursing; and
186.8 personal care assistance.

186.9 (e) "Home residence" means a residence owned or rented by the recipient either
186.10 alone, with roommates of the recipient's choosing, or with an unpaid responsible party
186.11 or legal representative; or a family foster home where the license holder lives with the
186.12 recipient and is not paid to provide home care services for the recipient.

186.13 (d) (f) "Medically necessary" has the meaning given in Minnesota Rules, parts
186.14 9505.0170 to 9505.0475.

186.15 (e) "Telehomecare" means the use of telecommunications technology by a home
186.16 health care professional to deliver home health care services, within the professional's
186.17 scope of practice, to a patient located at a site other than the site where the practitioner
186.18 is located.

186.19 (g) "Ventilator-dependent" means an individual who receives mechanical ventilation
186.20 for life support at least six hours per day and is expected to be or has been dependent on a
186.21 ventilator for at least 30 consecutive days.

186.22 Subd. 2. **Services covered.** Home care services covered under this section and
186.23 sections 256B.0653 256B.0652 to 256B.0656 and 256B.0659 include:

186.24 (1) nursing services under section sections 256B.0625, subdivision 6a, and
186.25 256B.0653;

186.26 (2) private duty nursing services under section sections 256B.0625, subdivision
186.27 7, and 256B.0654;

186.28 (3) home health services under section sections 256B.0625, subdivision 6a, and
186.29 256B.0653;

186.30 (4) personal care assistant services under section sections 256B.0625, subdivision
186.31 19a, and 256B.0659;

186.32 (5) supervision of personal care assistant services provided by a qualified
186.33 professional under section sections 256B.0625, subdivision 19a, and 256B.0659;

186.34 (6) qualified professional of personal care assistant services under the fiscal
186.35 intermediary option as specified in section 256B.0655, subdivision 7;

~~(7)~~ (6) face-to-face assessments by county public health nurses for services under ~~section~~ sections 256B.0625, subdivision 19a, and 256B.0659; and

~~(8)~~ (7) service updates and review of temporary increases for personal care assistant services by the county public health nurse for services under ~~section~~ sections 256B.0625, subdivision 19a, and 256B.0659.

Subd. 3. **Noncovered home care services.** The following home care services are not eligible for payment under medical assistance:

~~(1) skilled nurse visits for the sole purpose of supervision of the home health aide;~~

~~(2) a skilled nursing visit:~~

~~(i) only for the purpose of monitoring medication compliance with an established medication program for a recipient; or~~

~~(ii) to administer or assist with medication administration, including injections, prefilling syringes for injections, or oral medication set-up of an adult recipient, when as determined and documented by the registered nurse, the need can be met by an available pharmacy or the recipient is physically and mentally able to self-administer or prefill a medication;~~

~~(3) home care services to a recipient who is eligible for covered services under the Medicare program or any other insurance held by the recipient;~~

~~(4) services to other members of the recipient's household;~~

~~(5) a visit made by a skilled nurse solely to train other home health agency workers;~~

~~(6) any home care service included in the daily rate of the community-based residential facility where the recipient is residing;~~

~~(7) nursing and rehabilitation therapy services that are reasonably accessible to a recipient outside the recipient's place of residence, excluding the assessment, counseling and education, and personal assistant care;~~

~~(8) any home health agency service, excluding personal care assistant services and private duty nursing services, which are performed in a place other than the recipient's residence; and~~

~~(9) Medicare evaluation or administrative nursing visits on dual-eligible recipients that do not qualify for Medicare visit billing.~~

(1) services provided in a nursing facility, hospital, or intermediate care facility with exceptions in section 256B.0653;

(2) services for the sole purpose of monitoring medication compliance with an established medication program for a recipient;

(3) home care services for covered services under the Medicare program or any other insurance held by the recipient;

188.1 (4) services to other members of the recipient's household;
188.2 (5) any home care service included in the daily rate of the community-based
188.3 residential facility where the recipient is residing;
188.4 (6) nursing and rehabilitation therapy services that are reasonably accessible to a
188.5 recipient outside the recipient's place of residence, excluding the assessment, counseling
188.6 and education, and personal assistance care; or
188.7 (7) Medicare evaluation or administrative nursing visits on dual-eligible recipients
188.8 that do not qualify for Medicare visit billing.
188.9 Subd. 4. **~~Prior~~ Authorization; exceptions.** All home care services above the limits
188.10 in subdivision 11 must receive the commissioner's ~~prior~~ authorization before services
188.11 begin, except when:
188.12 (1) the home care services were required to treat an emergency medical condition
188.13 that if not immediately treated could cause a recipient serious physical or mental disability,
188.14 continuation of severe pain, or death. The provider must request retroactive authorization
188.15 no later than five working days after giving the initial service. The provider must be able
188.16 to substantiate the emergency by documentation such as reports, notes, and admission or
188.17 discharge histories;
188.18 (2) ~~the home care services were provided on or after the date on which the recipient's~~
188.19 ~~eligibility began, but before the date on which the recipient was notified that the case was~~
188.20 ~~opened. Authorization will be considered if the request is submitted by the provider~~
188.21 ~~within 20 working days of the date the recipient was notified that the case was opened;~~
188.22 a recipient's medical assistance eligibility has lapsed, is then retroactively reinstated,
188.23 and an authorization for home care services is completed based on the date of a current
188.24 assessment, eligibility, and request for authorization;
188.25 (3) a third-party payor for home care services has denied or adjusted a payment.
188.26 Authorization requests must be submitted by the provider within 20 working days of the
188.27 notice of denial or adjustment. A copy of the notice must be included with the request;
188.28 (4) the commissioner has determined that a county or state human services agency
188.29 has made an error; or
188.30 (5) ~~the professional nurse determines an immediate need for up to 40 skilled nursing~~
188.31 ~~or home health aide visits per calendar year and submits a request for authorization within~~
188.32 ~~20 working days of the initial service date, and medical assistance is determined to be~~
188.33 ~~the appropriate payer.~~ if a recipient enrolled in managed care experiences a temporary
188.34 disenrollment from a health plan, the commissioner shall accept the current health plan
188.35 authorization for personal care assistance services for up to 60 days. The request must
188.36 be received within the first 30 days of the disenrollment. If the recipient's reenrollment

in managed care is after the 60 days and before 90 days, the provider shall request an additional 30-day extension of the current health plan authorization, for a total limit of 90 days from the time of disenrollment.

~~Subd. 5. **Retroactive authorization.** A request for retroactive authorization will be evaluated according to the same criteria applied to prior authorization requests.~~

Subd. 6. ~~**Prior**~~ **Authorization.** (a) The commissioner, or the commissioner's designee, shall review the assessment, ~~service update,~~ request for temporary services, ~~request for flexible use option,~~ service plan, and any additional information that is submitted. The commissioner shall, within 30 days after receiving a complete request, assessment, and service plan, authorize home care services as ~~follows:~~ provided in this section.

~~(a) **Home health services.**~~ (b) ~~All~~ Home health services ~~provided by a home health aide~~ including skilled nurse visits and home health aide visits must be ~~prior~~ authorized by the commissioner or the commissioner's designee. ~~Prior~~ Authorization must be based on medical necessity and cost-effectiveness when compared with other care options. The commissioner must receive the request for authorization of skilled nurse visits and home health aide visits within 20 working days of the start of service. When home health services are used in combination with personal care and private duty nursing, the cost of all home care services shall be considered for cost-effectiveness. ~~The commissioner shall limit home health aide visits to no more than one visit each per day. The commissioner, or the commissioner's designee, may authorize up to two skilled nurse visits per day.~~

~~(b) **Ventilator-dependent recipients.**~~ (c) If the recipient is ventilator-dependent, the monthly medical assistance authorization for home care services shall not exceed what the commissioner would pay for care at the highest cost hospital designated as a long-term hospital under the Medicare program. For purposes of this paragraph, home care services means all direct care services provided in the home that would be included in the payment for care at the long-term hospital. ~~"Ventilator-dependent" means an individual who receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent for at least 30 consecutive days.~~ Recipients who meet the definition of ventilator dependent and the EN home care rating and utilize a combination of home care services are limited up to a total of 24 hours of home care services per day. Additional hours may be authorized when a recipient's assessment indicates a need for two staff to perform activities. Additional time is limited to four hours per day.

Subd. 7. ~~**Prior**~~ **Authorization; time limits.** (a) The commissioner or the commissioner's designee shall determine the time period for which ~~a prior~~ an authorization shall be effective ~~and, if flexible use has been requested, whether to allow the flexible use~~

~~option~~. If the recipient continues to require home care services beyond the duration of the ~~prior~~ authorization, the home care provider must request a new ~~prior~~ authorization. A personal care provider agency must request a new personal care assistant services assessment, or service update if allowed, at least 60 days prior to the end of the current ~~prior~~ authorization time period. The request for the assessment must be made on a form approved by the commissioner. ~~Under no circumstances, other than the exceptions in subdivision 4, shall a prior~~ An authorization must be valid ~~prior to the date the commissioner receives the request or~~ for no more than 12 months.

The amount and type of personal care assistant services authorized based upon the assessment and service plan must remain in effect for the recipient whether the recipient chooses a different provider or enrolls or disenrolls from a managed care plan under section 256B.0659, unless the service needs of the recipient change and a new assessment is warranted under section 256B.0655, subdivision 1b.

(b) A recipient who appeals a reduction in previously authorized home care services may continue previously authorized services, other than temporary services under subdivision 8, pending an appeal under section 256.045. The commissioner must ~~provide~~ ensure that the recipient has a copy of the most recent service plan that contains a detailed explanation of ~~why the authorized services~~ which areas of covered personal care assistant tasks are reduced ~~in amount from those requested by the home care provider~~ and provide notice of the amount of time per day reduced, and the reasons for the reduction in the recipient's notice of denial, termination, or reduction.

Subd. 8. **~~Prior~~ Authorization requests; temporary services.** The agency nurse, ~~the~~ independently enrolled private duty nurse, or county public health nurse may request a temporary authorization for home care services ~~by telephone~~. The commissioner may approve a temporary level of home care services based on the assessment, and service or care plan information, and primary payer coverage determination information as required. Authorization for a temporary level of home care services including nurse supervision is limited to the time specified by the commissioner, but shall not exceed 45 days~~, unless extended because the county public health nurse has not completed the required assessment and service plan, or the commissioner's determination has not been made~~. The level of services authorized under this provision shall have no bearing on a future ~~prior~~ authorization.

Subd. 9. **~~Prior~~ Authorization for foster care setting.** (a) Home care services provided in an adult or child foster care setting must receive ~~prior~~ authorization by the ~~department~~ commissioner according to the limits established in subdivision 11.

(b) The commissioner may not authorize:

191.1 (1) home care services that are the responsibility of the foster care provider under the
191.2 terms of the foster care placement agreement, difficulty of care, and administrative rules;
191.3 (2) personal care assistant services when the foster care license holder is also the
191.4 personal care provider or personal care assistant, unless the foster home is the licensed
191.5 provider's primary residence and unless the recipient can direct the recipient's own care, or
191.6 case management is provided as required in section 256B.0625, subdivision 19a; or
191.7 ~~(3) personal care assistant services when the responsible party is an employee of, or~~
191.8 ~~under contract with, or has any direct or indirect financial relationship with the personal~~
191.9 ~~care provider or personal care assistant, unless case management is provided as required~~
191.10 ~~in section 256B.0625, subdivision 19a; or~~
191.11 ~~(4)~~ (3) personal care assistant and private duty nursing services when the ~~number~~
191.12 ~~of foster care residents~~ licensed capacity is greater than four ~~unless the county responsible~~
191.13 ~~for the recipient's foster placement made the placement prior to April 1, 1992, requests~~
191.14 ~~that personal care assistant and private duty nursing services be provided, and case~~
191.15 ~~management is provided as required in section 256B.0625, subdivision 19a~~.
191.16 ~~Subd. 10.~~ **~~Limitation on payments.~~** ~~Medical assistance payments for home care~~
191.17 ~~services shall be limited according to subdivisions 4 to 12 and sections 256B.0654,~~
191.18 ~~subdivision 2, and 256B.0655, subdivisions 3 and 4.~~
191.19 Subd. 11. **Limits on services without ~~prior~~ authorization.** A recipient may receive
191.20 the following home care services during a calendar year:
191.21 (1) up to two face-to-face assessments to determine a recipient's need for personal
191.22 care assistant services;
191.23 (2) one service update done to determine a recipient's need for personal care assistant
191.24 services; and
191.25 (3) up to nine face-to-face skilled nurse visits.
191.26 Subd. 12. **Approval of home care services.** The commissioner or the
191.27 commissioner's designee shall determine the medical necessity of home care services, the
191.28 level of caregiver according to subdivision 2, and the institutional comparison according to
191.29 subdivisions 4 to 12 and sections 256B.0654, subdivision 2, and ~~256B.0655, subdivisions~~
191.30 ~~3 and 4~~ 256B.0659, the cost-effectiveness of services, and the amount, scope, and duration
191.31 of home care services reimbursable by medical assistance, based on the assessment,
191.32 primary payer coverage determination information as required, the service plan, the
191.33 recipient's age, the cost of services, the recipient's medical condition, and diagnosis or
191.34 disability. The commissioner may publish additional criteria for determining medical
191.35 necessity according to section 256B.04.

192.1 Subd. 13. **Recovery of excessive payments.** The commissioner shall seek
192.2 monetary recovery from providers of payments made for services which exceed the limits
192.3 established in this section and sections 256B.0653 to 256B.0656 and 256B.0659. This
192.4 subdivision does not apply to services provided to a recipient at the previously authorized
192.5 level pending an appeal under section 256.045, subdivision 10.

192.6 Subd. 14. **Referrals to Medicare providers required.** Home care providers that
192.7 do not participate in or accept Medicare assignment must refer and document the referral
192.8 of dual-eligible recipients to Medicare providers when Medicare is determined to be the
192.9 appropriate payer for services and supplies and equipment. Providers must be terminated
192.10 from participation in the medical assistance program for failure to make these referrals.

192.11 Subd. 15. **Quality assurance for program integrity.** The commissioner shall
192.12 maintain processes for monitoring ongoing program integrity including provider standards
192.13 and training, consumer surveys, and random reviews of documentation.

192.14 Subd. 16. **Oversight of enrolled providers.** The commissioner shall establish
192.15 an ongoing quality assurance process for home care services. The commissioner has
192.16 the authority to request proof of documentation of meeting provider standards, quality
192.17 standards of care, correct billing practices, and other information. Failure to provide access
192.18 and information to demonstrate compliance with laws, rules, or policies must result in
192.19 suspension, denial, or termination of the provider agency's enrollment with the department.

192.20 Sec. 26. Minnesota Statutes 2008, section 256B.0652, is amended to read:

192.21 **256B.0652 ~~PRIOR~~ AUTHORIZATION AND REVIEW OF HOME CARE**
192.22 **SERVICES.**

192.23 Subdivision 1. **State coordination.** The commissioner shall supervise the
192.24 coordination of the ~~prior~~ authorization and review of home care services that are
192.25 reimbursed by medical assistance.

192.26 Subd. 2. **Duties.** (a) The commissioner may contract with or employ ~~qualified~~
192.27 ~~registered nurses and~~ necessary ~~support~~ staff, or contract with qualified agencies, to
192.28 provide home care ~~prior~~ authorization and review services for medical assistance
192.29 recipients who are receiving home care services.

192.30 (b) Reimbursement for the ~~prior~~ authorization function shall be made through the
192.31 medical assistance administrative authority. The state shall pay the nonfederal share.
192.32 The functions will be to:

192.33 (1) assess the recipient's individual need for services required to be cared for safely
192.34 in the community;

193.1 (2) ensure that a ~~service~~ care plan that meets the recipient's needs is developed
193.2 by the appropriate agency or individual;
193.3 (3) ensure cost-effectiveness and nonduplication of medical assistance home care
193.4 services;
193.5 (4) recommend the approval or denial of the use of medical assistance funds to pay
193.6 for home care services;
193.7 (5) reassess the recipient's need for and level of home care services at a frequency
193.8 determined by the commissioner; ~~and~~
193.9 (6) conduct on-site assessments when determined necessary by the commissioner
193.10 and recommend changes to care plans that will provide more efficient and appropriate
193.11 home care~~.~~; and
193.12 (7) on the department's Web site:
193.13 (i) provide a link to MinnesotaHelp.info for a list of enrolled home care agencies
193.14 with the following information: main office address, contact information for the agency,
193.15 counties in which services are provided, type of home care services provided, whether
193.16 the personal care assistance choice option is offered, types of qualified professionals
193.17 employed, number of personal care assistants employed, and data on staff turnover; and
193.18 (ii) post data on home care services including information from both fee-for-service
193.19 and managed care plans as available.
193.20 (c) In addition, the commissioner or the commissioner's designee may:
193.21 (1) review care plans, service plans, and reimbursement data for utilization of
193.22 services that exceed community-based standards for home care, inappropriate home care
193.23 services, medical necessity, home care services that do not meet quality of care standards,
193.24 or unauthorized services and make appropriate referrals within the department or to other
193.25 appropriate entities based on the findings;
193.26 (2) assist the recipient in obtaining services necessary to allow the recipient to
193.27 remain safely in or return to the community;
193.28 (3) coordinate home care services with other medical assistance services under
193.29 section 256B.0625;
193.30 (4) assist the recipient with problems related to the provision of home care services;
193.31 (5) assure the quality of home care services; and
193.32 (6) assure that all liable third-party payers including, but not limited to, Medicare
193.33 have been used prior to medical assistance for home care services~~, including but not~~
193.34 ~~limited to, home health agency, elected hospice benefit, waivered services, alternative care~~
193.35 ~~program services, and personal care services~~.

194.1 (d) For the purposes of this section, "home care services" means medical assistance
194.2 services defined under section 256B.0625, subdivisions 6a, 7, and 19a.

194.3 Subd. 3. **Assessment and ~~prior~~ authorization process for persons receiving**
194.4 **personal care assistance and developmental disabilities services.** ~~Effective January 1,~~
194.5 ~~1996,~~ For purposes of providing informed choice, coordinating of local planning decisions,
194.6 and streamlining administrative requirements, the assessment and ~~prior~~ authorization
194.7 process for persons receiving both home care and home and community-based waivered
194.8 services for persons with developmental disabilities shall meet the requirements of
194.9 sections 256B.0651 and 256B.0653 to 256B.0656 with the following exceptions:

194.10 (a) Upon request for home care services and subsequent assessment by the public
194.11 health nurse under sections 256B.0651 and 256B.0653 to 256B.0656, the public health
194.12 nurse shall participate in the screening process, as appropriate, and, if home care
194.13 services are determined to be necessary, participate in the development of a service plan
194.14 coordinating the need for home care and home and community-based waivered services
194.15 with the assigned county case manager, the recipient of services, and the recipient's legal
194.16 representative, if any.

194.17 (b) The public health nurse shall give ~~prior~~ authorization for home care services
194.18 to the extent that home care services are:

194.19 (1) medically necessary;

194.20 (2) chosen by the recipient and their legal representative, if any, from the array of
194.21 home care and home and community-based waivered services available;

194.22 (3) coordinated with other services to be received by the recipient as described
194.23 in the service plan; and

194.24 (4) provided within the county's reimbursement limits for home care and home and
194.25 community-based waivered services for persons with developmental disabilities.

194.26 (c) If the public health agency is or may be the provider of home care services to the
194.27 recipient, the public health agency shall provide the commissioner of human services with
194.28 a written plan that specifies how the assessment and ~~prior~~ authorization process will be
194.29 held separate and distinct from the provision of services.

194.30 Sec. 27. Minnesota Statutes 2008, section 256B.0653, is amended to read:

194.31 **256B.0653 HOME HEALTH AGENCY ~~COVERED~~ SERVICES.**

194.32 Subdivision 1. **~~Homecare; skilled nurse visits~~ Scope.** ~~"Skilled nurse visits" are~~
194.33 ~~provided in a recipient's residence under a plan of care or service plan that specifies a level~~
194.34 ~~of care which the nurse is qualified to provide. These services are:~~

195.1 ~~(1) nursing services according to the written plan of care or service plan and accepted~~
195.2 ~~standards of medical and nursing practice in accordance with chapter 148;~~
195.3 ~~(2) services which due to the recipient's medical condition may only be safely and~~
195.4 ~~effectively provided by a registered nurse or a licensed practical nurse;~~
195.5 ~~(3) assessments performed only by a registered nurse; and~~
195.6 ~~(4) teaching and training the recipient, the recipient's family, or other caregivers~~
195.7 ~~requiring the skills of a registered nurse or licensed practical nurse.~~ This section applies to
195.8 home health agency services including, home health aide, skilled nursing visits, physical
195.9 therapy, occupational therapy, respiratory therapy, and speech language pathology therapy.
195.10 Subd. 2. ~~**Telehomecare; skilled nurse visits**~~ **Definitions.** ~~Medical assistance~~
195.11 ~~covers skilled nurse visits according to section 256B.0625, subdivision 6a, provided via~~
195.12 ~~telehomecare, for services which do not require hands-on care between the home care~~
195.13 ~~nurse and recipient. The provision of telehomecare must be made via live, two-way~~
195.14 ~~interactive audiovisual technology and may be augmented by utilizing store-and-forward~~
195.15 ~~technologies. Store-and-forward technology includes telehomecare services that do not~~
195.16 ~~occur in real time via synchronous transmissions, and that do not require a face-to-face~~
195.17 ~~encounter with the recipient for all or any part of any such telehomecare visit. Individually~~
195.18 ~~identifiable patient data obtained through real-time or store-and-forward technology must~~
195.19 ~~be maintained as health records according to sections 144.291 to 144.298. If the video~~
195.20 ~~is used for research, training, or other purposes unrelated to the care of the patient, the~~
195.21 ~~identity of the patient must be concealed. A communication between the home care nurse~~
195.22 ~~and recipient that consists solely of a telephone conversation, facsimile, electronic mail, or~~
195.23 ~~a consultation between two health care practitioners, is not to be considered a telehomecare~~
195.24 ~~visit. Multiple daily skilled nurse visits provided via telehomecare are allowed. Coverage~~
195.25 ~~of telehomecare is limited to two visits per day. All skilled nurse visits provided via~~
195.26 ~~telehomecare must be prior authorized by the commissioner or the commissioner's~~
195.27 ~~designee and will be covered at the same allowable rate as skilled nurse visits provided~~
195.28 ~~in-person.~~ For the purposes of this section, the following terms have the meanings given.
195.29 (a) "Assessment" means an evaluation of the recipient's medical need for home
195.30 health agency services by a registered nurse or appropriate therapist that is conducted
195.31 within 30 days of a request and as specified in Code of Federal Regulations, title 42,
195.32 sections 484.1 to 494.55.
195.33 (b) "Home care therapies" means occupational, physical, and respiratory therapy
195.34 and speech-language pathology services, provided in the home by a Medicare-certified
195.35 home health agency.

196.1 (c) "Home health agency services" means services delivered in the recipient's home
196.2 residence, except as specified in section 256B.0625, by a home health agency to a recipient
196.3 with medical needs due to illness, disability, or physical conditions.
196.4 (d) "Home health aide" means an employee of a home health agency who meets
196.5 the requirements of Code of Federal Regulations, title 42, sections 484.1 to 494.55, and
196.6 completes medically oriented tasks written in the plan of care for a recipient.
196.7 (e) "Home health agency" means a home care provider agency that is
196.8 Medicare-certified satisfying the requirements of Code of Federal Regulations, title 42,
196.9 sections 484.1 to 494.55.
196.10 (f) "Occupational therapy services" mean the services defined in Minnesota Rules,
196.11 part 9505.0390.
196.12 (g) "Physical therapy services" mean the services defined in Minnesota Rules, part
196.13 9505.0390.
196.14 (h) "Respiratory therapy services" mean the services defined in chapter 147C and
196.15 Minnesota Rules, part 4668.0003, subpart 37.
196.16 (i) "Speech-language pathology services" mean the services defined in Minnesota
196.17 Rules, part 9505.0390.
196.18 (j) "Skilled nurse visit" means a professional nursing visit to complete nursing tasks
196.19 required due to a recipient's medical condition that can only be safely provided by a
196.20 professional nurse to restore and maintain optimal health.
196.21 (k) "Store-and-forward technology" means telehomecare services that do not occur
196.22 in real time via synchronous transmissions such as diabetic and vital sign monitoring.
196.23 (l) "Telehomecare" means the use of telecommunications technology via
196.24 live, two-way interactive audiovisual technology which may be augmented by
196.25 store-and-forward technology.
196.26 (m) "Telehomecare skilled nurse visit" means a visit by a professional nurse to
196.27 deliver a skilled nurse visit to a recipient located at a site other than the site where the
196.28 nurse is located and is used in combination with face-to-face skilled nurse visits to
196.29 adequately meet the recipient's needs.
196.30 Subd. 3. ~~**Therapies through home health agencies**~~ **Home health aide visits.**
196.31 ~~(a) Medical assistance covers physical therapy and related services, including specialized~~
196.32 ~~maintenance therapy. Services provided by a physical therapy assistant shall be~~
196.33 ~~reimbursed at the same rate as services performed by a physical therapist when the~~
196.34 ~~services of the physical therapy assistant are provided under the direction of a physical~~
196.35 ~~therapist who is on the premises. Services provided by a physical therapy assistant that are~~
196.36 ~~provided under the direction of a physical therapist who is not on the premises shall be~~

197.1 ~~reimbursed at 65 percent of the physical therapist rate. Direction of the physical therapy~~
197.2 ~~assistant must be provided by the physical therapist as described in Minnesota Rules, part~~
197.3 ~~9505.0390, subpart 1, item B. The physical therapist and physical therapist assistant may~~
197.4 ~~not both bill for services provided to a recipient on the same day.~~
197.5 ~~(b) Medical assistance covers occupational therapy and related services, including~~
197.6 ~~specialized maintenance therapy. Services provided by an occupational therapy assistant~~
197.7 ~~shall be reimbursed at the same rate as services performed by an occupational therapist~~
197.8 ~~when the services of the occupational therapy assistant are provided under the direction of~~
197.9 ~~the occupational therapist who is on the premises. Services provided by an occupational~~
197.10 ~~therapy assistant under the direction of an occupational therapist who is not on the~~
197.11 ~~premises shall be reimbursed at 65 percent of the occupational therapist rate. Direction~~
197.12 ~~of the occupational therapy assistant must be provided by the occupational therapist as~~
197.13 ~~described in Minnesota Rules, part 9505.0390, subpart 1, item B. The occupational~~
197.14 ~~therapist and occupational therapist assistant may not both bill for services provided~~
197.15 ~~to a recipient on the same day.~~
197.16 (a) Home health aide visits must be provided by a certified home health aide
197.17 using a written plan of care that is updated in compliance with Medicare regulations.
197.18 A home health aide shall provide hands-on personal care, perform simple procedures
197.19 as an extension of therapy or nursing services, and assist in instrumental activities of
197.20 daily living as defined in section 256B.0659. Home health aide visits must be provided
197.21 in the recipient's home.
197.22 (b) All home health aide visits must have authorization under section 256B.0652.
197.23 The commissioner shall limit home health aide visits to no more than one visit per day
197.24 per recipient.
197.25 (c) Home health aides must be supervised by a registered nurse or an appropriate
197.26 therapist when providing services that are an extension of therapy.
197.27 Subd. 4. **Skilled nurse visit services.** (a) Skilled nurse visit services must be
197.28 provided by a registered nurse or a licensed practical nurse under the supervision of a
197.29 registered nurse, according to the written plan of care and accepted standards of medical
197.30 and nursing practice according to chapter 148. Skilled nurse visit services must be ordered
197.31 by a physician and documented in a plan of care that is reviewed and approved by the
197.32 ordering physician at least once every 60 days. All skilled nurse visits must be medically
197.33 necessary and provided in the recipient's home residence except as allowed under section
197.34 256B.0625, subdivision 6a.
197.35 (b) Skilled nurse visits include face-to-face and telehomecare visits with a limit of
197.36 up to two visits per day per recipient. All visits must be based on assessed needs.

198.1 (c) Telehomecare skilled nurse visits are allowed when the recipient's health status
198.2 can be accurately measured and assessed without a need for a face-to-face, hands-on
198.3 encounter. All telehomecare skilled nurse visits must have authorization and are paid at
198.4 the same allowable rates as face-to-face skilled nurse visits.

198.5 (d) The provision of telehomecare must be made via live, two-way interactive
198.6 audiovisual technology and may be augmented by utilizing store-and-forward
198.7 technologies. Individually identifiable patient data obtained through real-time or
198.8 store-and-forward technology must be maintained as health records according to sections
198.9 144.291 to 144.298. If the video is used for research, training, or other purposes unrelated
198.10 to the care of the patient, the identity of the patient must be concealed.

198.11 (e) Authorization for skilled nurse visits must be completed under section
198.12 256B.0652. A total of nine face-to-face skilled nurses visits per calendar year do not
198.13 require authorization. All telehomecare skilled nurse visits require authorization.

198.14 Subd. 5. **Home care therapies.** (a) Home care therapies include the following:
198.15 physical therapy, occupational therapy, respiratory therapy, and speech and language
198.16 pathology therapy services.

198.17 (b) Home care therapies must be:

198.18 (1) provided in the recipient's residence after it has been determined the recipient is
198.19 unable to access outpatient therapy;

198.20 (2) prescribed, ordered, or referred by a physician and documented in a plan of care
198.21 and reviewed, according to Minnesota Rules, part 9505.0390;

198.22 (3) assessed by an appropriate therapist; and

198.23 (4) provided by a Medicare-certified home health agency enrolled as a Medicaid
198.24 provider agency.

198.25 (c) Restorative and specialized maintenance therapies must be provided according to
198.26 Minnesota Rules, part 9505.0390. Physical and occupational therapy assistants may be
198.27 used as allowed under Minnesota Rules, part 9505.0390, subpart 1, item B.

198.28 (d) For both physical and occupational therapies, the therapist and the therapist's
198.29 assistant may not both bill for services provided to a recipient on the same day.

198.30 Subd. 6. **Noncovered home health agency services.** The following are not eligible
198.31 for payment under medical assistance as a home health agency service:

198.32 (1) telehomecare skilled nurses services that is communication between the home
198.33 care nurse and recipient that consists solely of a telephone conversation, facsimile,
198.34 electronic mail, or a consultation between two health care practitioners;

198.35 (2) the following skilled nurse visits:

(i) for the purpose of monitoring medication compliance with an established medication program for a recipient;

(ii) administering or assisting with medication administration, including injections, prefilling syringes for injections, or oral medication setup of an adult recipient, when, as determined and documented by the registered nurse, the need can be met by an available pharmacy or the recipient or a family member is physically and mentally able to self-administer or prefill a medication;

(iii) services done for the sole purpose of supervision of the home health aide or personal care assistant;

(iv) services done for the sole purpose to train other home health agency workers;

(v) services done for the sole purpose of blood samples or lab draw or Synagis injections when the recipient is able to access these services outside the home; and

(vi) Medicare evaluation or administrative nursing visits required by Medicare;

(3) home health aide visits when the following activities are the sole purpose for the visit: companionship, socialization, household tasks, transportation, and education; and

(4) home care therapies provided in other settings such as a clinic, day program, or as an inpatient or when the recipient can access therapy outside of the recipient's residence.

Sec. 28. Minnesota Statutes 2008, section 256B.0654, is amended to read:

256B.0654 PRIVATE DUTY NURSING.

Subdivision 1. **Definitions.** ~~(a) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person. Assessments for private duty nursing shall be conducted by a registered private duty nurse. Assessments for medical assistance home care services for developmental disabilities and alternative care services for developmentally disabled home and community-based waivered recipients may be conducted by the county public health nurse to ensure coordination and avoid duplication.~~

~~(b)~~ (a) "Complex ~~and regular~~ private duty nursing care" means~~:~~

~~(1) complex care is private duty~~ nursing services provided to recipients who are ventilator dependent or for whom a physician has certified that ~~were it not for private duty nursing~~ the recipient ~~would meet~~ meets the criteria for inpatient hospital intensive care unit (ICU) level of care~~; and~~

~~(2) regular care is private duty nursing provided to all other recipients~~.

(b) "Private duty nursing" means ongoing professional nursing services by a registered or licensed practical nurse including assessment, professional nursing tasks, and education, based on an assessment and physician orders to maintain or restore optimal health of the recipient.

200.1 (c) "Private duty nursing agency" means a medical assistance enrolled provider
200.2 licensed under chapter 144A to provide private duty nursing services.
200.3 (d) "Regular private duty nursing" means nursing services provided to a recipient
200.4 who is considered stable and not at an inpatient hospital intensive care unit level of care,
200.5 but may have episodes of instability that are not life threatening.
200.6 (e) "Shared private duty nursing" means the provision of nursing services by a
200.7 private duty nurse to two recipients at the same time and in the same setting.
200.8 Subd. 2. **Authorization; private duty nursing services.** (a) All private duty
200.9 nursing services shall be ~~prior~~ authorized by the commissioner or the commissioner's
200.10 designee. ~~Prior~~ Authorization for private duty nursing services shall be based on
200.11 medical necessity and cost-effectiveness when compared with alternative care options.
200.12 The commissioner may authorize medically necessary private duty nursing services in
200.13 quarter-hour units when:
200.14 (1) the recipient requires more individual and continuous care than can be provided
200.15 during a skilled nurse visit; or
200.16 (2) the cares are outside of the scope of services that can be provided by a home
200.17 health aide or personal care assistant.
200.18 (b) The commissioner may authorize:
200.19 (1) up to two times the average amount of direct care hours provided in nursing
200.20 facilities statewide for case mix classification "K" as established by the annual cost report
200.21 submitted to the department by nursing facilities in May 1992;
200.22 (2) private duty nursing in combination with other home care services up to the total
200.23 cost allowed under section 256B.0655, subdivision 4;
200.24 (3) up to 16 hours per day if the recipient requires more nursing than the maximum
200.25 number of direct care hours as established in clause (1) and the recipient meets the hospital
200.26 admission criteria established under Minnesota Rules, parts 9505.0501 to 9505.0540.
200.27 (c) The commissioner may authorize up to 16 hours per day of medically necessary
200.28 private duty nursing services or up to 24 hours per day of medically necessary private duty
200.29 nursing services until such time as the commissioner is able to make a determination of
200.30 eligibility for recipients who are cooperatively applying for home care services under
200.31 the community alternative care program developed under section 256B.49, or until it is
200.32 determined by the appropriate regulatory agency that a health benefit plan is or is not
200.33 required to pay for appropriate medically necessary health care services. Recipients
200.34 or their representatives must cooperatively assist the commissioner in obtaining this
200.35 determination. Recipients who are eligible for the community alternative care program
200.36 may not receive more hours of nursing under this section and sections 256B.0651,

201.1 256B.0653, ~~256B.0655, and~~ 256B.0656, and 256B.0659 than would otherwise be
201.2 authorized under section 256B.49.

201.3 Subd. 2a. **Private duty nursing services.** (a) Private duty nursing services must
201.4 be used:

201.5 (1) in the recipient's home or outside the home when normal life activities require;

201.6 (2) when the recipient requires more individual and continuous care than can be
201.7 provided during a skilled nurse visit; and

201.8 (3) when the care required is outside of the scope of services that can be provided by
201.9 a home health aide or personal care assistant.

201.10 (b) Private duty nursing services must be:

201.11 (1) assessed by a registered nurse on a form approved by the commissioner;

201.12 (2) ordered by a physician and documented in a plan of care that is reviewed by the
201.13 physician at least once every 60 days; and

201.14 (3) authorized by the commissioner under section 256B.0652.

201.15 Subd. 2b. **Noncovered private duty nursing services.** Private duty nursing
201.16 services do not cover the following:

201.17 (1) nursing services by a nurse who is the foster care provider of a person who has
201.18 not reached 18 years of age unless allowed under subdivision 4;

201.19 (2) nursing services to more than two persons receiving shared private duty nursing
201.20 services from a private duty nurse in a single setting; and

201.21 (3) nursing services provided by a registered nurse or licensed practical nurse who is
201.22 the recipient's legal guardian or related to the recipient as spouse, parent, family foster
201.23 parent, or child, whether by blood, marriage, or adoption except as specified in section
201.24 256B.0652, subdivision 4.

201.25 Subd. 3. **Shared private duty nursing ~~care~~ option.** (a) Medical assistance
201.26 payments for shared private duty nursing services by a private duty nurse shall be limited
201.27 according to this subdivision. ~~For the purposes of this section and sections 256B.0651,~~
201.28 ~~256B.0653, 256B.0655, and 256B.0656, "private duty nursing agency" means an agency~~
201.29 ~~licensed under chapter 144A to provide private duty nursing services.~~ Unless otherwise
201.30 provided in this subdivision, all other statutory and regulatory provisions relating to
201.31 private duty nursing services apply to shared private duty nursing services. Nothing in
201.32 this subdivision shall be construed to reduce the total number of private duty nursing
201.33 hours authorized for an individual recipient.

201.34 ~~(b) Recipients of private duty nursing services may share nursing staff and the~~
201.35 ~~commissioner shall provide a rate methodology for shared private duty nursing. For two~~
201.36 ~~persons sharing nursing care, the rate paid to a provider shall not exceed 1.5 times the~~

~~regular private duty nursing rates paid for serving a single individual by a registered nurse or licensed practical nurse. These rates apply only to situations in which both recipients are present and receive shared private duty nursing care on the date for which the service is billed. No more than two persons may receive shared private duty nursing services from a private duty nurse in a single setting.~~

~~(c)~~ (b) Shared private duty nursing ~~care~~ is the provision of nursing services by a private duty nurse to two medical assistance eligible recipients at the same time and in the same setting. This subdivision does not apply when a private duty nurse is caring for multiple recipients in more than one setting.

(c) For the purposes of this subdivision, "setting" means:

(1) the home residence or foster care home of one of the individual recipients as defined in section 256B.0651; ~~or~~

(2) a child care program licensed under chapter 245A or operated by a local school district or private school; ~~or~~

(3) an adult day care service licensed under chapter 245A; or

(4) outside the home residence or foster care home of one of the recipients when normal life activities take the recipients outside the home.

~~This subdivision does not apply when a private duty nurse is caring for multiple recipients in more than one setting.~~

(d) The private duty nursing agency must offer the recipient the option of shared or one-on-one private duty nursing services. The recipient may withdraw from participating in a shared service arrangement at any time.

~~(d)~~ (e) The recipient or the recipient's legal representative, and the recipient's physician, in conjunction with the ~~home health care~~ private duty nursing agency, shall determine:

(1) whether shared private duty nursing care is an appropriate option based on the individual needs and preferences of the recipient; and

(2) the amount of shared private duty nursing services authorized as part of the overall authorization of nursing services.

~~(e)~~ (f) The recipient or the recipient's legal representative, in conjunction with the private duty nursing agency, shall approve the setting, grouping, and arrangement of shared private duty nursing care based on the individual needs and preferences of the recipients. Decisions on the selection of recipients to share services must be based on the ages of the recipients, compatibility, and coordination of their care needs.

~~(f)~~ (g) The following items must be considered by the recipient or the recipient's legal representative and the private duty nursing agency, and documented in the recipient's health service record:

(1) the additional training needed by the private duty nurse to provide care to two recipients in the same setting and to ensure that the needs of the recipients are met appropriately and safely;

(2) the setting in which the shared private duty nursing care will be provided;

(3) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting;

(4) a contingency plan which accounts for absence of the recipient in a shared private duty nursing setting due to illness or other circumstances;

(5) staffing backup contingencies in the event of employee illness or absence; and

(6) arrangements for additional assistance to respond to urgent or emergency care needs of the recipients.

~~(g) The provider must offer the recipient or responsible party the option of shared or one-on-one private duty nursing services. The recipient or responsible party can withdraw from participating in a shared service arrangement at any time.~~

(h) ~~The private duty nursing agency must document the following in the health service record for each individual recipient sharing private duty nursing care~~ The documentation for shared private duty nursing must be on a form approved by the commissioner for each individual recipient sharing private duty nursing. The documentation must be part of the recipient's health service record and include:

(1) permission by the recipient or the recipient's legal representative for the maximum number of shared nursing ~~care~~ hours per week chosen by the recipient and permission for shared private duty nursing services provided in and outside the recipient's home residence;

~~(2) permission by the recipient or the recipient's legal representative for shared private duty nursing services provided outside the recipient's residence;~~

~~(3) permission by the recipient or the recipient's legal representative for others to receive shared private duty nursing services in the recipient's residence;~~

~~(4)~~ (2) revocation by the recipient or the recipient's legal representative ~~of~~ for the shared private duty nursing ~~care authorization, or the shared care to be provided to others in the recipient's residence, or the shared private duty nursing services to be provided outside~~ permission, or services provided to others in and outside the recipient's residence; and

~~(5)~~ (3) daily documentation of the shared private duty nursing services provided by each identified private duty nurse, including:

(i) the names of each recipient receiving shared private duty nursing services ~~together~~;

(ii) the setting for the shared services, including the starting and ending times that the recipient received shared private duty nursing care; and

(iii) notes by the private duty nurse regarding changes in the recipient's condition, problems that may arise from the sharing of private duty nursing services, and scheduling and care issues.

~~(i) Unless otherwise provided in this subdivision, all other statutory and regulatory provisions relating to private duty nursing services apply to shared private duty nursing services.~~

~~Nothing in this subdivision shall be construed to reduce the total number of private duty nursing hours authorized for an individual recipient under subdivision 2.~~

(i) The commissioner shall provide a rate methodology for shared private duty nursing. For two persons sharing nursing care, the rate paid to a provider must not exceed 1.5 times the regular private duty nursing rates paid for serving a single individual by a registered nurse or licensed practical nurse. These rates apply only to situations in which both recipients are present and receive shared private duty nursing care on the date for which the service is billed.

Subd. 4. **Hardship criteria; private duty nursing.** (a) Payment is allowed for extraordinary services that require specialized nursing skills and are provided by parents of minor children, family foster parents, spouses, and legal guardians who are providing private duty nursing care under the following conditions:

(1) the provision of these services is not legally required of the parents, family foster parents, spouses, or legal guardians;

(2) the services are necessary to prevent hospitalization of the recipient; and

(3) the recipient is eligible for state plan home care or a home and community-based waiver and one of the following hardship criteria are met:

(i) the parent, spouse, or legal guardian resigns from a part-time or full-time job to provide nursing care for the recipient; ~~or~~

(ii) the parent, spouse, or legal guardian goes from a full-time to a part-time job with less compensation to provide nursing care for the recipient; ~~or~~

(iii) the parent, spouse, or legal guardian takes a leave of absence without pay to provide nursing care for the recipient; or

(iv) because of labor conditions, special language needs, or intermittent hours of care needed, the parent, spouse, or legal guardian is needed in order to provide adequate private duty nursing services to meet the medical needs of the recipient.

205.1 (b) Private duty nursing may be provided by a parent, spouse, family foster parent,
205.2 or legal guardian who is a nurse licensed in Minnesota. Private duty nursing services
205.3 provided by a parent, spouse, family foster parent, or legal guardian cannot be used in
205.4 lieu of nursing services covered and available under liable third-party payors, including
205.5 Medicare. The private duty nursing provided by a parent, family foster parent, spouse, or
205.6 legal guardian must be included in the service plan. Authorized skilled nursing services
205.7 for a single recipient or recipients with the same residence and provided by the parent,
205.8 family foster parent, spouse, or legal guardian may not exceed 50 percent of the total
205.9 approved nursing hours, or eight hours per day, whichever is less, up to a maximum of
205.10 40 hours per week. A parent or parents, family foster parents, spouse, or legal guardian
205.11 shall not provide more than 40 hours of services in a seven-day period. For parents,
205.12 family foster parents, and legal guardians, 40 hours is the total amount allowed regardless
205.13 of the number of children or adults who receive services. Nothing in this subdivision
205.14 precludes the parent's, family foster parents', spouse's, or legal guardian's obligation of
205.15 assuming the nonreimbursed family responsibilities of emergency backup caregiver and
205.16 primary caregiver.

205.17 (c) A parent, family foster parent, or a spouse may not be paid to provide private
205.18 duty nursing care if:

205.19 (1) the parent or spouse fails to pass a criminal background check according to
205.20 chapter 245C, or if;

205.21 (2) it has been determined by the home health care agency, the case manager, or the
205.22 physician that the private duty nursing care provided by the parent, family foster parents,
205.23 spouse, or legal guardian is unsafe; or

205.24 (3) the parent, family foster parents, spouse, or legal guardian do not follow
205.25 physician orders.

205.26 (d) For purposes of this section, "assessment" means a review and evaluation of a
205.27 recipient's need for home care services conducted in person. Assessments for private duty
205.28 nursing must be conducted by a registered nurse.

205.29 Sec. 29. Minnesota Statutes 2008, section 256B.0655, subdivision 1b, is amended to
205.30 read:

205.31 Subd. 1b. **Assessment.** "Assessment" means a review and evaluation of a recipient's
205.32 need for home care services conducted in person. Assessments for personal care assistant
205.33 services shall be conducted by the county public health nurse or a certified public
205.34 health nurse under contract with the county. A face-to-face An in-person assessment
205.35 must include: documentation of health status, determination of need, evaluation of

service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistant services is determined under this section or sections 256B.0651, 256B.0653, 256B.0654, and 256B.0656, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. ~~A face-to-face assessment for personal care assistant services is conducted on those recipients who have never had a county public health nurse assessment. A face-to-face~~ An in-person assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistant services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistant service. A service update may be completed by telephone, used when there is no need for an increase in personal care assistant services, and used for two consecutive assessments if followed by a face-to-face assessment. A service update must be completed on a form approved by the commissioner. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party or personal care provider agency.

Sec. 30. Minnesota Statutes 2008, section 256B.0655, subdivision 4, is amended to read:

Subd. 4. **~~Prior~~ Authorization; personal care assistance and qualified professional.** ~~The commissioner, or the commissioner's designee, shall review the assessment, service update, request for temporary services, request for flexible use option, service plan, and any additional information that is submitted. The commissioner shall, within 30 days after receiving a complete request, assessment, and service plan, authorize home care services as follows:~~

~~(1)~~ (a) All personal care assistant services ~~and~~, supervision by a qualified professional, ~~if requested by the recipient,~~ and additional services beyond the limits established in section 256B.0652, subdivision 11, must be ~~prior~~ authorized by the commissioner or the commissioner's designee before services begin except for the

assessments established in ~~section~~ sections 256B.0651, subdivision 11, and 256B.0655, subdivision 1b. The authorization for personal care assistance and qualified professional services under section 256B.0659 must be completed within 30 calendar days after receiving a complete request.

(b) The amount of personal care assistant services authorized must be based on the recipient's home care rating. The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner identifying the following:

~~A child may not be found to be dependent in an activity of daily living if because of the child's age an adult would either perform the activity for the child or assist the child with the activity and the amount of assistance needed is similar to the assistance appropriate for a typical child of the same age. Based on medical necessity, the commissioner may authorize:~~

~~(A) up to two times the average number of direct care hours provided in nursing facilities for the recipient's comparable case mix level; or~~

~~(B) up to three times the average number of direct care hours provided in nursing facilities for recipients who have complex medical needs or are dependent in at least seven activities of daily living and need physical assistance with eating or have a neurological diagnosis; or~~

~~(C) up to 60 percent of the average reimbursement rate, as of July 1, 1991, for care provided in a regional treatment center for recipients who have Level I behavior, plus any inflation adjustment as provided by the legislature for personal care service; or~~

~~(D) up to the amount the commissioner would pay, as of July 1, 1991, plus any inflation adjustment provided for home care services, for care provided in a regional treatment center for recipients referred to the commissioner by a regional treatment center preadmission evaluation team. For purposes of this clause, home care services means all services provided in the home or community that would be included in the payment to a regional treatment center; or~~

~~(E) up to the amount medical assistance would reimburse for facility care for recipients referred to the commissioner by a preadmission screening team established under section 256B.0911 or 256B.092; and~~

~~(F) a reasonable amount of time for the provision of supervision by a qualified professional of personal care assistant services, if a qualified professional is requested by the recipient or responsible party.~~

~~(2) The number of direct care hours shall be determined according to the annual cost report submitted to the department by nursing facilities. The average number of direct care~~

208.1 ~~hours, as established by May 1, 1992, shall be calculated and incorporated into the home~~
208.2 ~~care limits on July 1, 1992. These limits shall be calculated to the nearest quarter hour.~~
208.3 ~~(3) The home care rating shall be determined by the commissioner or the~~
208.4 ~~commissioner's designee based on information submitted to the commissioner by the~~
208.5 ~~county public health nurse on forms specified by the commissioner. The home care rating~~
208.6 ~~shall be a combination of current assessment tools developed under sections 256B.0911~~
208.7 ~~and 256B.501 with an addition for seizure activity that will assess the frequency and~~
208.8 ~~severity of seizure activity and with adjustments, additions, and clarifications that are~~
208.9 ~~necessary to reflect the needs and conditions of recipients who need home care including~~
208.10 ~~children and adults under 65 years of age. The commissioner shall establish these forms~~
208.11 ~~and protocols under this section and sections 256B.0651, 256B.0653, 256B.0654, and~~
208.12 ~~256B.0656 and shall use an advisory group, including representatives of recipients,~~
208.13 ~~providers, and counties, for consultation in establishing and revising the forms and~~
208.14 ~~protocols.~~
208.15 ~~(4) A recipient shall qualify as having complex medical needs if the care required is~~
208.16 ~~difficult to perform and because of recipient's medical condition requires more time than~~
208.17 ~~community-based standards allow or requires more skill than would ordinarily be required~~
208.18 ~~and the recipient needs or has one or more of the following:~~
208.19 ~~(A) daily tube feedings;~~
208.20 ~~(B) daily parenteral therapy;~~
208.21 ~~(C) wound or decubiti care;~~
208.22 ~~(D) postural drainage, percussion, nebulizer treatments, suctioning, tracheotomy~~
208.23 ~~care, oxygen, mechanical ventilation;~~
208.24 ~~(E) catheterization;~~
208.25 ~~(F) ostomy care;~~
208.26 ~~(G) quadriplegia; or~~
208.27 ~~(H) other comparable medical conditions or treatments the commissioner determines~~
208.28 ~~would otherwise require institutional care.~~
208.29 ~~(5) A recipient shall qualify as having Level I behavior if there is reasonable~~
208.30 ~~supporting evidence that the recipient exhibits, or that without supervision, observation, or~~
208.31 ~~redirection would exhibit, one or more of the following behaviors that cause, or have the~~
208.32 ~~potential to cause:~~
208.33 ~~(A) injury to the recipient's own body;~~
208.34 ~~(B) physical injury to other people; or~~
208.35 ~~(C) destruction of property.~~

209.1 ~~(6) Time authorized for personal care relating to Level I behavior in paragraph~~
209.2 ~~(5), clauses (A) to (C), shall be based on the predictability, frequency, and amount of~~
209.3 ~~intervention required.~~
209.4 ~~(7) A recipient shall qualify as having Level II behavior if the recipient exhibits on a~~
209.5 ~~daily basis one or more of the following behaviors that interfere with the completion of~~
209.6 ~~personal care assistant services under subdivision 2, paragraph (a):~~
209.7 ~~(A) unusual or repetitive habits;~~
209.8 ~~(B) withdrawn behavior; or~~
209.9 ~~(C) offensive behavior.~~
209.10 ~~(8) A recipient with a home care rating of Level II behavior in paragraph (7), clauses~~
209.11 ~~(A) to (C), shall be rated as comparable to a recipient with complex medical needs under~~
209.12 ~~paragraph (4). If a recipient has both complex medical needs and Level II behavior, the~~
209.13 ~~home care rating shall be the next complex category up to the maximum rating under~~
209.14 ~~paragraph (1), clause (B).~~
209.15 (1) total number of dependencies of activities of daily living as defined in section
209.16 256B.0659;
209.17 (2) number of complex health-related functions as defined in section 256B.0659; and
209.18 (3) number of behavior criteria as defined in section 256B.0659.
209.19 (c) The methodology to determine total time for personal care assistance services is
209.20 based on the median paid units per day for each home care rating from fiscal year 2007
209.21 data. Each home care rating has a base level of hours assigned. Additional time is added
209.22 through the assessment and identification of the following:
209.23 (1) 30 additional minutes per day for a dependency in each critical activity of daily
209.24 living as defined in section 256B.0659;
209.25 (2) 30 additional minutes per day for each complex health-related need as defined in
209.26 section 256B.0659; and
209.27 (3) 30 additional minutes per day for each behavior criteria as defined in section
209.28 256B.0659.
209.29 (d) A limit of 96 units of qualified professional supervision may be authorized for
209.30 each recipient receiving personal care assistance services. A request to the commissioner
209.31 to exceed this total in a calendar year must be requested by the personal care provider
209.32 agency on a form approved by the commissioner.

209.33 Sec. 31. Minnesota Statutes 2008, section 256B.0657, subdivision 8, is amended to
209.34 read:

210.1 Subd. 8. **Self-directed budget requirements.** The budget for the provision of the
210.2 self-directed service option shall be equal to the greater of either established based on:
210.3 (1) the annual amount of personal care assistant services under section 256B.0655
210.4 that the recipient has used in the most recent 12-month period assessed personal care
210.5 assistance units, not to exceed the maximum number of personal care assistance units
210.6 available, as determined by section 256B.0655; or and
210.7 (2) the amount determined using the consumer support grant methodology under
210.8 section 256.476, subdivision 11, except that the budget amount shall include the federal
210.9 and nonfederal share of the average service costs. the personal care assistance unit rate:
210.10 (i) with a reduction to the unit rate to pay for a program administrator as defined in
210.11 subdivision 10; and
210.12 (ii) an additional adjustment to the unit rate as needed to ensure cost neutrality for
210.13 the state.

210.14 Sec. 32. Minnesota Statutes 2008, section 256B.0657, is amended by adding a
210.15 subdivision to read:
210.16 Subd. 12. **Enrollment and evaluation.** Enrollment in the self-directed supports
210.17 option is available to current personal care assistance recipients upon annual personal care
210.18 assistance reassessment, with a maximum enrollment of 1,000 people in the first fiscal
210.19 year of implementation and an additional 1,000 people in the second fiscal year. The
210.20 commissioner shall evaluate the self-directed supports option during the first two years of
210.21 implementation and make any necessary changes prior to the option becoming available
210.22 statewide.

210.23 Sec. 33. **[256B.0659] PERSONAL CARE ASSISTANCE PROGRAM.**
210.24 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in
210.25 paragraphs (b) to (p) have the meanings given unless otherwise provided in text.
210.26 (b) "Activities of daily living" means grooming, dressing, bathing, transferring,
210.27 mobility, positioning, eating, and toileting.
210.28 (c) "Behavior" means categories to determine the home care rating and is based on
210.29 the criteria found in this section. Level I behavior means physical aggression to self or
210.30 others and destruction of property.
210.31 (d) "Complex health-related needs" means a category to determine the home care
210.32 rating and is based on the criteria found in this section.
210.33 (e) "Critical activities of daily living" means transferring, mobility, eating, and
210.34 toileting.

211.1 (f) "Dependency in activities of daily living" means a person requires assistance to
211.2 begin or complete one or more of the activities of daily living.
211.3 (g) "Health-related functions" means functions that can be delegated or assigned
211.4 by a licensed health care professional under state law to be performed by a personal
211.5 care assistant.
211.6 (h) "Instrumental activities of daily living" means activities to include meal planning
211.7 and preparation; basic assistance with paying bills; shopping for food, clothing, and
211.8 other essential items; performing household tasks integral to the personal care assistance
211.9 services; communication by telephone and other media; and traveling, including to
211.10 medical appointments, and participating in the community.
211.11 (i) " Managing employee" has the same definition as described in Code of Federal
211.12 Regulations, title 42, section 455.
211.13 (j) "Qualified professional" means a professional providing supervision of personal
211.14 care assistance services and staff as defined in section 256B.0625, subdivision 19c.
211.15 (k) "Personal care assistance provider agency" means a medical assistance enrolled
211.16 provider that provides or assists with providing personal care assistance services and
211.17 includes personal care assistance provider organizations, personal care assistance choice
211.18 agency, class A licensed nursing agency, and Medicare-certified home health agency.
211.19 (l) "Personal care assistant" means an individual employed by a personal care
211.20 assistance agency that provides personal care assistance services.
211.21 (m) "Personal care assistance care plan" means a written description of personal
211.22 care assistance services developed by the personal care assistance provider according
211.23 to the service plan.
211.24 (n) "Responsible party" means an individual who is capable of providing the support
211.25 necessary to assist the recipient to live in the community.
211.26 (o) "Self-administered medication" means medication taken orally, by injection or
211.27 insertion, or applied topically without the need for assistance.
211.28 (p) "Service plan" means a written summary of the assessment and description of the
211.29 services needed by the recipient.
211.30 Subd. 2. **Personal care assistance services; covered services.** (a) The personal
211.31 care assistance services eligible for payment include services and supports furnished
211.32 to an individual, as needed, to assist in:
211.33 (1) activities of daily living;
211.34 (2) health-related procedures and tasks;
211.35 (3) assistance with behavior needs; and
211.36 (4) instrumental activities of daily living.

212.1 (b) Activities of daily living include the following covered services:
212.2 (1) dressing, including assistance with choosing, application, and changing of
212.3 clothing and application of special appliances, wraps, or clothing;
212.4 (2) grooming, including assistance with basic hair care, oral care, shaving, applying
212.5 cosmetics and deodorant, and care of eyeglasses and hearing aids. Nail care is included,
212.6 except for recipients who are diabetic or have poor circulation;
212.7 (3) bathing, including assistance with basic personal hygiene and skin care;
212.8 (4) eating, including assistance with hand washing and application of orthotics
212.9 required for eating, transfers, and feeding;
212.10 (5) transfers, including assistance with transferring the recipient from one seating or
212.11 reclining area to another;
212.12 (6) mobility, including assistance with ambulation, including use of a wheelchair.
212.13 Mobility does not include providing transportation for a recipient;
212.14 (7) positioning, including assistance with positioning or turning a recipient for
212.15 necessary care and comfort; and
212.16 (8) toileting, including assistance with helping recipient with bowel or bladder
212.17 elimination and care including transfers, mobility, positioning, feminine hygiene, use of
212.18 toileting equipment or supplies, cleansing the perineal area, inspection of the skin, and
212.19 adjusting clothing.
212.20 (c) Health-related procedures or tasks include the following covered services:
212.21 (1) range of motion and passive exercise to maintain a recipient's optimal level of
212.22 strength and muscle functioning;
212.23 (2) assistance with self-administered medication as defined by this section, including
212.24 reminders to take medication, bringing medication to the recipient, and assistance with
212.25 opening medication under the direction of the recipient or responsible party;
212.26 (3) interventions for seizure disorders, including monitoring and observation; and
212.27 (4) other activities considered within the scope of the personal care service and
212.28 meeting the definition of health-related procedures or tasks under this section.
212.29 (d) A personal care assistant may perform health-related procedures and tasks
212.30 associated with the complex health-related needs of a recipient if the tasks meet the
212.31 definition of health-related procedures and tasks under this section and the personal care
212.32 assistant is trained by a qualified professional and demonstrates competency to safely
212.33 complete the task. Delegation of health-related procedures and tasks and all training must
212.34 be documented in the personal care assistance care plan and the recipient's and personal
212.35 care assistant's files.

213.1 (e) For a personal care assistant to provide the health-related procedures and tasks of
213.2 tracheostomy suctioning and services to recipients on ventilator support there must be:
213.3 (1) delegation and training by a registered nurse, certified or licensed respiratory
213.4 therapist, or a physician;
213.5 (2) utilization of clean rather than sterile procedure;
213.6 (3) specialized training about the health-related functions and equipment, including
213.7 ventilator operation and maintenance;
213.8 (4) individualized training regarding the needs of the recipient; and
213.9 (5) supervision by a qualified professional who is a registered nurse.
213.10 (f) A personal care assistant may observe and redirect the recipient for episodes
213.11 where there is a need for redirection due to behaviors. Training of the personal care
213.12 assistant must occur based on the needs of the recipient, the personal care assistance care
213.13 plan, and any other support services provided.
213.14 Subd. 3. **Noncovered personal care assistance services.** (a) Personal care
213.15 assistance services are not eligible for medical assistance payment under this section
213.16 when provided:
213.17 (1) by the recipient's spouse, parent of a recipient under the age of 18, paid legal
213.18 guardian, licensed foster provider, except as allowed under section 256B.0651, subdivision
213.19 9, or responsible party;
213.20 (2) in lieu of other staffing options in a residential or child care setting;
213.21 (3) solely as a child care or babysitting service; or
213.22 (4) without authorization by the commissioner or the commissioner's designee.
213.23 (b) The following personal care services are not eligible for medical assistance
213.24 payment under this section when provided in residential settings:
213.25 (1) when the provider of home care services who is not related by blood, marriage,
213.26 or adoption owns or otherwise controls the living arrangement, including licensed or
213.27 unlicensed services; or
213.28 (2) when personal care assistance services are the responsibility of a residential or
213.29 program license holder under the terms of a service agreement and administrative rules.
213.30 (c) Other specific tasks not covered under paragraph (a) or (b) that are not eligible
213.31 for medical assistance reimbursement for personal care assistance services under this
213.32 section include:
213.33 (1) sterile procedures;
213.34 (2) injections of fluids and medications into veins, muscles, or skin;
213.35 (3) home maintenance or chore services;

214.1 (4) homemaker services not an integral part of assessed personal care assistance
214.2 services needed by a recipient;
214.3 (5) application of restraints or implementation of procedures under section 245.825;
214.4 (6) instrumental activities of daily living for children under the age of 18; and
214.5 (7) assessments for personal care assistance services by personal care assistance
214.6 provider agencies or by independently enrolled registered nurses.
214.7 Subd. 4. **Assessment for personal care assistance services.** (a) An assessment
214.8 as defined in section 256B.0655, subdivision 1b, must be completed for personal care
214.9 assistance services.
214.10 (b) The following conditions apply to the assessment:
214.11 (1) a person must be assessed as dependent in an activity of daily living based
214.12 on the person's need, on a daily basis, for:
214.13 (i) cueing or supervision to complete the task; or
214.14 (ii) hands-on assistance to complete the task; and
214.15 (2) a child may not be found to be dependent in an activity of daily living if because
214.16 of the child's age an adult would either perform the activity for the child or assist the child
214.17 with the activity. Assistance needed is the assistance appropriate for a typical child of
214.18 the same age.
214.19 (c) Assessment for complex health-related needs must meet the criteria in this
214.20 paragraph. During the assessment process, a recipient qualifies as having complex
214.21 health-related functions if the recipient has one or more of the interventions that are
214.22 ordered by a physician, specified in a personal care assistance care plan, and found in
214.23 the following:
214.24 (1) tube feedings requiring:
214.25 (i) a gastro/jejunostomy tube; or
214.26 (ii) continuous tube feeding lasting longer than 12 hours per day;
214.27 (2) wounds described as:
214.28 (i) stage III or stage IV;
214.29 (ii) multiple wounds;
214.30 (iii) requiring sterile or clean dressing changes or a wound vac; or
214.31 (iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require
214.32 specialized care;
214.33 (3) parenteral therapy described as:
214.34 (i) IV therapy more than two times per week lasting longer than four hours for
214.35 each treatment; or
214.36 (ii) total parenteral nutrition (TPN) daily;

215.1 (4) respiratory interventions including:
215.2 (i) oxygen required more than eight hours per day;
215.3 (ii) respiratory vest more than one time per day;
215.4 (iii) bronchial drainage treatments more than two times per day;
215.5 (iv) sterile or clean suctioning more than six times per day;
215.6 (v) dependence on another to apply respiratory ventilation augmentation devises
215.7 such as BiPAP and CPAP; and
215.8 (vi) ventilator dependence under section 256B.0652;
215.9 (5) insertion and maintenance of catheter including:
215.10 (i) sterile catheter changes more than one time per month;
215.11 (ii) clean self-catheterization more than six times per day; or
215.12 (iii) bladder irrigations;
215.13 (6) bowel program more than two times per week requiring more than 30 minutes to
215.14 perform each time;
215.15 (7) neurological intervention including:
215.16 (i) seizures more than two times per week and requiring significant physical
215.17 assistance to maintain safety; or
215.18 (ii) swallowing disorders diagnosed by a physician and requiring specialized
215.19 assistance from another on a daily basis; and
215.20 (8) other congenital or acquired diseases creating a need for significantly increased
215.21 direct hands-on assistance and interventions in six to eight activities of daily living.
215.22 (d) An assessment of behaviors must meet the criteria in this paragraph. A recipient
215.23 qualifies as having a need for assistance due to behaviors if the recipient's behavior requires
215.24 assistance at least four times per week and shows one or more of the following behaviors:
215.25 (1) physical aggression towards self, others, or property that requires immediate
215.26 response of another;
215.27 (2) increased vulnerability due to cognitive deficits or socially inappropriate
215.28 behavior; or
215.29 (3) verbally aggressive and resistive to care.
215.30 Subd. 5. **Service and support planning and referral.** (a) The assessor, with the
215.31 recipient or responsible party, shall review the assessment information and determine
215.32 referrals for other payers, services, and community supports as appropriate.
215.33 (b) The recipient must be referred for evaluation, services, or supports that are
215.34 appropriate to help meet the recipient's needs including, but not limited to, the following
215.35 circumstances:

216.1 (1) when there is another payer who is responsible to provide the service to meet
216.2 the recipient's needs;
216.3 (2) when the recipient qualifies for assistance due to mental illness or behaviors
216.4 under this section, a referral for a mental health diagnostic and functional assessment
216.5 must be completed, or referral must be made for other specific mental health services
216.6 or community services;
216.7 (3) when the recipient is eligible for medical assistance and meets medical assistance
216.8 eligibility for a home health aide or skilled nurse visit;
216.9 (4) when the recipient would benefit from an evaluation for another service; and
216.10 (5) when there is a more appropriate service to meet the assessed needs.
216.11 (c) The reimbursement rates for public health nurse visits that relate to the provision
216.12 of personal care assistance services under this section and section 256B.0625, subdivision
216.13 19a, are:
216.14 (1) $210.50 for a face-to-face assessment visit;
216.15 (2) $105.25 for each service update; and
216.16 (3) $105.25 for each request for a temporary service increase.
216.17 (d) The rates specified in paragraph (c) must be adjusted to reflect provider rate
216.18 increases for personal care assistance services that are approved by the legislature for the
216.19 fiscal year ending June 30, 2000, and subsequent fiscal years. Any requirements applied
216.20 by the legislature to provider rate increases for personal care assistance services also
216.21 apply to adjustments under this paragraph.
216.22 (e) Effective July 1, 2008, the payment rate for an assessment under this section and
216.23 section 256B.0651 shall be reduced by 25 percent when the assessment is not completed
216.24 on time and the service agreement documentation is not submitted in time to continue
216.25 services. The commissioner shall reduce the amount of the claim for those assessments
216.26 that are not submitted on time.
216.27 Subd. 6. **Service plan.** The service plan must be completed by the assessor with the
216.28 recipient and responsible party on a form determined by the commissioner and include
216.29 a summary of the assessment with a description of the need, authorized amount, and
216.30 expected outcomes and goals of personal care assistance services. The recipient and
216.31 the provider chosen by the recipient or responsible party must be given a copy of the
216.32 completed service plan within ten working days. The recipient or responsible party must
216.33 be given information by the assessor about the options in the personal care assistance
216.34 program to allow for review and decision making.
216.35 Subd. 7. **Personal care assistance care plan.** (a) Each recipient must have a current
216.36 personal care assistance care plan based on the service plan in subdivision 21 that is

217.1 developed by the qualified professional with the recipient and responsible party. A copy of
217.2 the most current personal care assistance care plan is required to be in the recipient's home
217.3 and in the recipient's file at the provider agency.

217.4 (b) The personal care assistance care plan must have the following components:

217.5 (1) start and end date of the care plan;

217.6 (2) recipient demographic information, including name and telephone number;

217.7 (3) emergency numbers, procedures, and a description of measures to address
217.8 identified safety and vulnerability issues, including a backup staffing plan;

217.9 (4) name of responsible party and instructions for contact;

217.10 (5) description of the recipient's individualized needs for assistance with activities of
217.11 daily living, instrumental activities of daily living, health-related tasks, and behaviors; and

217.12 (6) dated signatures of recipient or responsible party and qualified professional.

217.13 (c) The personal care assistance care plan must have instructions and comments
217.14 about the recipient's needs for assistance and any special instructions or procedures
217.15 required. The month-to-month plan for the use of personal care assistance services is part
217.16 of the personal care assistance care plan. The personal care assistance care plan must
217.17 be completed within the first week after start of services with a personal care provider
217.18 agency and must be updated as needed when there is a change in need for personal care
217.19 assistance services. A new personal care assistance care plan is required annually at the
217.20 time of the reassessment.

217.21 Subd. 8. **Communication with recipient's physician.** The personal care assistance
217.22 program requires communication with the recipient's physician about a recipient's assessed
217.23 needs for personal care assistance services. The commissioner shall work with the state
217.24 medical director to develop options for communication with the recipient's physician.

217.25 Subd. 9. **Responsible party; generally.** (a) "Responsible party" means an
217.26 individual who is capable of providing the support necessary to assist the recipient to live
217.27 in the community.

217.28 (b) A responsible party must be 18 years of age, actively participate in planning and
217.29 directing of personal care assistance services, and attend all assessments for the recipient.

217.30 (c) A responsible party must not be the:

217.31 (1) personal care assistant;

217.32 (2) home care provider agency owner or staff; or

217.33 (3) county staff acting as part of employment.

217.34 (d) A licensed family foster parent who lives with the recipient may be the
217.35 responsible party as long as the family foster parent meets the other responsible party
217.36 requirements.

218.1 (e) A responsible party is required when:

218.2 (1) the person is a minor according to section 524.5-102, subdivision 10;

218.3 (2) the person is an incapacitated adult according to section 524.5-102, subdivision
218.4 6, resulting in a court-appointed guardian; or

218.5 (3) the assessment according to section 256B.0911 determines that the recipient is in
218.6 need of a responsible party to direct the recipient's care.

218.7 (f) There may be two persons designated as the responsible party for reasons such
218.8 as divided households and court-ordered custodies. Each person named as responsible
218.9 party must meet the program criteria and responsibilities.

218.10 (g) The recipient or the recipient's legal representative shall appoint a responsible
218.11 party if necessary to direct and supervise the care provided to the recipient. The
218.12 responsible party must be identified at the time of assessment and listed on the recipient's
218.13 service agreement and personal care assistance care plan.

218.14 Subd. 10. **Responsible party; duties; delegation.** (a) A responsible party with a
218.15 personal care assistance provider agency shall enter into a written agreement, on a form
218.16 determined by the commissioner, to perform the following duties:

218.17 (1) be available while care is provided in a method agreed upon by the individual
218.18 or the individual's legal representative and documented in the recipient's personal care
218.19 assistance care plan;

218.20 (2) monitor personal care assistance services to ensure the recipient's personal care
218.21 assistance care plan is being followed; and

218.22 (3) review and sign personal care assistance time sheets after services are provided
218.23 to provide verification that personal care assistance services were provided.

218.24 Failure to provide the support required by the recipient must result in a referral to the
218.25 county common entry point.

218.26 (b) Responsible parties who are parents of minors or guardians of minors or
218.27 incapacitated persons may delegate the responsibility to another adult who is not the
218.28 personal care assistant during a temporary absence of at least 24 hours but not more
218.29 than six months. The person delegated as a responsible party must be able to meet the
218.30 definition of the responsible party, except that the delegated responsible party is required
218.31 to reside with the recipient only while serving as the responsible party. The responsible
218.32 party must ensure that the delegate performs the functions of the responsible party, is
218.33 identified at the time of the assessment, and is listed on the personal care assistance
218.34 care plan. The responsible party must communicate to the personal care assistance
218.35 provider agency about the need for a delegate responsible party, including the name of the

219.1 delegated responsible party, dates the delegated responsible party will be acting as the
219.2 responsible party, and contact numbers.

219.3 Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant
219.4 must meet the following requirements:

219.5 (1) be at least 18 years of age and if 16 or 17 years of age only if:

219.6 (i) supervised by a qualified professional every 60 days; and

219.7 (ii) employed by only one personal care assistance provider agency responsible
219.8 for compliance with current labor laws;

219.9 (2) be employed by a personal care assistance provider agency;

219.10 (3) enroll with the department as a non-pay-to provider after clearing a background
219.11 study. Before a personal care assistant provides services, the personal care assistance
219.12 provider agency must initiate a background study on the personal care assistant under
219.13 chapter 245C, and the personal care assistance provider agency must have received a
219.14 notice from the commissioner that the personal care assistant is:

219.15 (i) not disqualified under section 245C.14; or

219.16 (ii) is disqualified, but the personal care assistant has received a set aside of the
219.17 disqualification under section 245C.22;

219.18 (4) be able to effectively communicate with the recipient and personal care
219.19 assistance provider agency;

219.20 (5) be able to provide covered personal care assistance services according to the
219.21 recipient's personal care assistance care plan, respond appropriately to recipient needs,
219.22 and report changes in the recipient's condition to the supervising qualified professional
219.23 or physician;

219.24 (6) not be a consumer of personal care assistance services;

219.25 (7) maintain daily written records including, but not limited to, time sheets under
219.26 subdivision 12;

219.27 (8) complete standardized training as determined or approved by the commissioner
219.28 before completing enrollment. Personal care assistant training must include successful
219.29 completion of the following training components: basic first aid, vulnerable adult, child
219.30 maltreatment, OSHA universal precautions, basic roles and responsibilities of personal
219.31 care assistants including information about assistance with lifting and transfers for
219.32 recipients, orientation to positive behavior practices, emergency preparedness, fraud
219.33 issues, and completion of time sheets.Upon completion of the training components, the
219.34 personal care assistant must demonstrate the competency to provide assistance to the
219.35 recipient. Personal care assistant training and orientation must be completed within the

220.1 first seven days after the services begin and be directed to the needs of the recipient and
220.2 the recipient's personal care assistance care plan; and
220.3 (9) be limited to providing and being paid for no more than 310 hours per month of
220.4 personal care assistance services that is determined by the commissioner regardless of
220.5 the number of recipients being served or the number of personal care assistance provider
220.6 agencies enrolled with.
220.7 (b) A legal guardian may be a personal care assistant if the guardian is not being paid
220.8 for the guardian services and meets the criteria for personal care assistants in paragraph (a).
220.9 (c) Persons who do not qualify as a personal care assistant include parents and
220.10 stepparents of minors, spouses, paid legal guardians, foster care providers, except as
220.11 otherwise allowed in section 256B.0625, subdivision 19a, or staff of a residential setting.
220.12 Subd. 12. **Documentation of personal care assistance services provided.** (a)
220.13 Personal care assistance services for a recipient must be documented daily by each personal
220.14 care assistant, on a time sheet form approved by the commissioner. All documentation
220.15 may be Web-based, electronic, or paper documentation. The completed form must be
220.16 submitted on a monthly basis to the provider and kept in the recipient's health record.
220.17 (b) The activity documentation must correspond to the personal care assistance care
220.18 plan and be reviewed by the qualified professional.
220.19 (c) The personal care assistant time sheet must be on a form approved by the
220.20 commissioner documenting time the personal care assistant provides services in the home.
220.21 The following criteria must be included in the time sheet:
220.22 (1) full name of personal care assistant and individual provider number;
220.23 (2) provider name and telephone numbers;
220.24 (3) full name of recipient;
220.25 (4) consecutive dates, including month, day, and year, and arrival and departure
220.26 time with a.m. or p.m. notations;
220.27 (5) signatures of recipient or the responsible party;
220.28 (6) personal signature of the personal care assistant;
220.29 (7) any shared care provided, if applicable;
220.30 (8) a statement that it is a federal crime to provide false information on personal
220.31 care service billings for medical assistance payments; and
220.32 (9) dates and location of recipient stays in a hospital, care facility, or incarceration.
220.33 Subd. 13. **Qualified professional; qualifications.** (a) The qualified professional
220.34 must be employed by a personal care assistance provider agency and meet the definition
220.35 under section 256B.0625, subdivision 19c. Before a qualified professional provides
220.36 services, the personal care assistance provider agency must initiate a background study on

221.1 the qualified professional under chapter 245C, and the personal care assistance provider
221.2 agency must have received a notice from the commissioner that the qualified professional:
221.3 (1) is not disqualified under section 245C.14; or
221.4 (2) is disqualified, but the qualified professional has received a set aside of the
221.5 disqualification under section 245C.22.
221.6 (b) The qualified professional shall perform the duties of training, supervision, and
221.7 evaluation of the personal care assistance staff and evaluation of the effectiveness of
221.8 personal care assistance services. The qualified professional shall:
221.9 (1) develop and monitor with the recipient a personal care assistance care plan based
221.10 on the service plan and individualized needs of the recipient;
221.11 (2) develop and monitor with the recipient a monthly plan for the use of personal
221.12 care assistance services;
221.13 (3) review documentation of personal care assistance services provided;
221.14 (4) provide training and ensure competency for the personal care assistant in the
221.15 individual needs of the recipient; and
221.16 (5) document all training, communication, evaluations, and needed actions to
221.17 improve performance of the personal care assistants.
221.18 (c) The qualified professional shall complete the provider training with basic
221.19 information about the personal care assistance program approved by the commissioner
221.20 within six months of the date hired by a personal care assistance provider agency.
221.21 Qualified professionals who have completed the required trainings as an employee with a
221.22 personal care assistance provider agency do not need to repeat the required trainings if they
221.23 are hired by another agency, if they have completed the training within the last three years.
221.24 Subd. 14. **Qualified professional; duties.** (a) All personal care assistants must
221.25 be supervised by a qualified professional or in a joint supervision relationship with the
221.26 recipient or the responsible party.
221.27 (b) Through direct training, observation, return demonstrations, and consultation
221.28 with the staff and the recipient, the qualified professional must ensure and document
221.29 that the personal care assistant is:
221.30 (1) capable of providing the required personal care assistance services;
221.31 (2) knowledgeable about the plan of personal care assistance services before services
221.32 are performed; and
221.33 (3) able to identify conditions that should be immediately brought to the attention of
221.34 the qualified professional.
221.35 (c) The qualified professional shall evaluate the personal care assistant within the
221.36 first 14 days of starting to provide services for a recipient, except for those providing

222.1 services under the personal care assistant choice option under subdivision 19. The
222.2 qualified professional shall evaluate the personal care assistance services for a recipient
222.3 through direct observation of a personal care assistant's work:
222.4 (1) at least every 90 days thereafter for the first year of a recipient's services; and
222.5 (2) every 120 days after the first year of a recipient's service, or whenever needed for
222.6 response to a recipient's request for increased supervision of the personal care assistance
222.7 staff.
222.8 (d) Communication with the recipient is a part of the evaluation process of the
222.9 personal care assistance staff.
222.10 (e) At each supervisory visit, the qualified professional shall evaluate personal care
222.11 assistance services including the following information:
222.12 (1) satisfaction level of the recipient with personal care assistance services;
222.13 (2) review of the month-to-month plan for use of personal care assistance services;
222.14 (3) review of documentation of personal care assistance services provided;
222.15 (4) whether the personal care assistance services are meeting the goals of the service
222.16 as stated in the personal care assistance care plan and service plan;
222.17 (5) a written record of the results of the evaluation and actions taken to correct any
222.18 deficiencies in the work of a personal care assistant; and
222.19 (6) revision of the personal care assistance care plan as necessary in consultation
222.20 with the recipient or responsible party, to meet the needs of the recipient.
222.21 (f) The qualified professional shall complete the required documentation in the
222.22 agency recipient and employee files and the recipient's home, including the following
222.23 documentation:
222.24 (1) the personal care assistance care plan based on the service plan and individualized
222.25 needs of the recipient;
222.26 (2) a month-to-month plan for use of personal care assistance services;
222.27 (3) changes in need of the recipient requiring a change to the level of service and the
222.28 personal care assistance care plan;
222.29 (4) evaluation results of supervision visits and identified issues with personal care
222.30 assistance staff with actions taken;
222.31 (5) all communication with the recipient and personal care assistance staff; and
222.32 (6) hands-on training or individualized training for the care of the recipient.
222.33 (g) The documentation in paragraph (f) must be completed on agency forms.
222.34 (h) The services that are not eligible for payment as qualified professional services
222.35 include:

223.1 (1) direct professional nursing tasks that could be assessed and authorized as skilled
223.2 nursing tasks;
223.3 (2) supervision of personal care assistance completed by telephone;
223.4 (3) agency administrative activities;
223.5 (4) training other than the individualized training required to provide care for a
223.6 recipient; and
223.7 (5) any other activity that is not described in this section.
223.8 Subd. 15. **Flexible use.** (a) "Flexible use" means the scheduled use of authorized
223.9 hours of personal care assistance services, which vary within a service authorization
223.10 period covering no more than six months, in order to more effectively meet the needs and
223.11 schedule of the recipient. Each 12-month service agreement is divided into two six-month
223.12 authorization date spans. No more than 75 percent of the total authorized units for a
223.13 12-month service agreement may be used in a six-month date span.
223.14 (b) Authorization of flexible use occurs during the authorization process under
223.15 section 256B.0652. The flexible use of authorized hours does not increase the total
223.16 amount of authorized hours available to a recipient. The commissioner shall not authorize
223.17 additional personal care assistance services to supplement a service authorization that
223.18 is exhausted before the end date under a flexible service use plan, unless the assessor
223.19 determines a change in condition and a need for increased services is established.
223.20 Authorized hours not used within the six-month period must not be carried over to another
223.21 time period.
223.22 (c) A recipient who has terminated personal care assistance services before the end
223.23 of the 12-month authorization period must not receive additional hours upon reapplying
223.24 during the same 12-month authorization period, except if a change in condition is
223.25 documented. Services must be prorated for the remainder of the 12-month authorization
223.26 period based on the first six-month assessment.
223.27 (d) The recipient, responsible party, and qualified professional must develop a
223.28 written month-to-month plan of the projected use of personal care assistance services that
223.29 is part of the personal care assistance care plan and ensures:
223.30 (1) that the health and safety needs of the recipient are met throughout both date
223.31 spans of the authorization period; and
223.32 (2) that the total authorized amount of personal care assistance services for each date
223.33 span must not be used before the end of each date span in the authorization period.
223.34 (e) The personal care assistance provider agency shall monitor the use of personal
223.35 care assistance services to ensure health and safety needs of the recipient are met
223.36 throughout both date spans of the authorization period. The commissioner or the

224.1 commissioner's designee shall provide written notice to the provider and the recipient or
224.2 responsible party when a recipient is at risk of exceeding the personal care assistance
224.3 services prior to the end of the six-month period.
224.4 (f) Misuse and abuse of the flexible use of personal care assistance services resulting
224.5 in the overuse of units in a manner where the recipient will not have enough units to meet
224.6 their needs for assistance and ensure health and safety for the entire six-month date span
224.7 may lead to an action by the commissioner. The commissioner may take action including,
224.8 but not limited to: (1) restricting recipients to service authorizations of no more than one
224.9 month in duration; (2) requiring the recipient to have a responsible party; and (3) requiring
224.10 a qualified professional to monitor and report services on a monthly basis.
224.11 Subd. 16. **Shared services.** (a) Medical assistance payments for shared personal
224.12 care assistance services are limited according to this subdivision.
224.13 (b) Shared service is the provision of personal care assistance services by a personal
224.14 care assistant to two or three recipients, eligible for medical assistance, who voluntarily
224.15 enter into an agreement to receive services at the same time and in the same setting.
224.16 (c) For the purposes of this subdivision, "setting" means:
224.17 (1) the home residence or family foster care home of one or more of the individual
224.18 recipients; or
224.19 (2) a child care program licensed under chapter 245A or operated by a local school
224.20 district or private school.
224.21 (d) Shared personal care assistance services follow the same criteria for covered
224.22 services as subdivision 2.
224.23 (e) Noncovered shared personal care assistance services include the following:
224.24 (1) services for more than three recipients by one personal care assistant at one time;
224.25 (2) staff requirements for child care programs under chapter 245C;
224.26 (3) caring for multiple recipients in more than one setting;
224.27 (4) additional units of personal care assistance based on the selection of the option;
224.28 and
224.29 (5) use of more than one personal care assistance provider agency for the shared
224.30 care services.
224.31 (f) The option of shared personal care assistance is elected by the recipient or the
224.32 responsible party with the assistance of the assessor. The option must be determined
224.33 appropriate based on the ages of the recipients, compatibility, and coordination of their
224.34 assessed care needs. The recipient or the responsible party, in conjunction with the
224.35 qualified professional, shall arrange the setting and grouping of shared services based
224.36 on the individual needs and preferences of the recipients. The personal care assistance

225.1 provider agency shall offer the recipient or the responsible party the option of shared or
225.2 one-on-one personal care assistance services or a combination of both. The recipient or
225.3 the responsible party may withdraw from participating in a shared services arrangement at
225.4 any time.

225.5 (g) Authorization for the shared service option must be determined by the
225.6 commissioner based on the criteria that the shared service is appropriate to meet all of the
225.7 recipients' needs and their health and safety is maintained. The authorization of shared
225.8 services is part of the overall authorization of personal care assistance services. Nothing
225.9 in this subdivision must be construed to reduce the total number of hours authorized for
225.10 an individual recipient.

225.11 (h) A personal care assistant providing shared personal care assistance services must:

225.12 (1) receive training specific for each recipient served; and

225.13 (2) follow all required documentation requirements for time and services provided.

225.14 (i) A qualified professional shall:

225.15 (1) evaluate the ability of the personal care assistant to provide services for all of
225.16 the recipients in a shared setting;

225.17 (2) visit the shared setting as services are being provided at least once every six
225.18 months or whenever needed for response to a recipient's request for increased supervision
225.19 of the personal care assistance staff;

225.20 (3) provide ongoing monitoring and evaluation of the effectiveness and
225.21 appropriateness of the shared services;

225.22 (4) develop a contingency plan with each of the recipients which accounts for
225.23 absence of the recipient in a share services setting due to illness or other circumstances;

225.24 (5) obtain permission from each of the recipients who are sharing a personal care
225.25 assistant for number of shared hours for services provided inside and outside the home
225.26 residence; and

225.27 (6) document the training completed by the personal care assistants specific to the
225.28 shared setting and recipients sharing services.

225.29 Subd. 17. **Shared services; rates.** The commissioner shall establish a rate system
225.30 for shared personal care assistance services. For two persons sharing services, the rate
225.31 paid to a provider must not exceed one and one-half times the rate paid for serving a single
225.32 individual, and for three persons sharing services, the rate paid to a provider must not
225.33 exceed twice the rate paid for serving a single individual. These rates apply only when all
225.34 of the criteria for the shared care personal care assistance service have been met.

225.35 Subd. 18. **Personal care assistance choice option; generally.** (a) The
225.36 commissioner may allow a recipient of personal care assistance services to use a fiscal

226.1 intermediary to assist the recipient in paying and account for medically necessary covered
226.2 personal care assistance services. Unless otherwise provided in this section, all other
226.3 statutory and regulatory provisions relating to personal care assistance services apply to a
226.4 recipient using the personal care assistance choice option.

226.5 (b) Personal care assistance choice is an option of the personal care assistance
226.6 program that allows the recipient who receives personal care assistance services to be
226.7 responsible for the hiring, training, scheduling, and termination of personal care assistants.
226.8 This program offers greater control and choice for the recipient in deciding who provides
226.9 the personal care assistance service and when the service is scheduled. The recipient or
226.10 the recipient's responsible party must choose a personal care assistance choice provider
226.11 agency as a fiscal intermediary. This personal care assistance choice provider agency
226.12 manages payroll, invoices the state, is responsible for all payroll related taxes and
226.13 insurance, and is responsible for providing the consumer training and support in managing
226.14 the recipient's personal care assistance services.

226.15 Subd. 19. **Personal care assistance choice option; qualifications; duties.** (a)
226.16 Under personal care assistance choice, the recipient or responsible party shall:

226.17 (1) recruit, hire, schedule, and terminate personal care assistants and a qualified
226.18 professional;

226.19 (2) develop a personal care assistance care plan based on the assessed needs
226.20 and addressing the health and safety of the recipient with the assistance of a qualified
226.21 professional as needed;

226.22 (3) orient and train the personal care assistant with assistance as needed from the
226.23 qualified professional;

226.24 (4) supervise and evaluate the personal care assistant with the qualified professional,
226.25 who is required to visit at least every 180 days;

226.26 (5) monitor and verify in writing and report to the personal care assistance choice
226.27 agency the number of hours worked by the personal care assistant and the qualified
226.28 professional;

226.29 (6) engage in an annual face-to-face reassessment to determine continuing eligibility
226.30 and service authorization; and

226.31 (7) use the same personal care assistance choice provider agency if shared personal
226.32 assistance care is being used.

226.33 (b) The personal care assistance choice provider agency shall:

226.34 (1) meet all personal care assistance provider agency standards;

226.35 (2) enter into a written agreement with the recipient, responsible party, and personal
226.36 care assistants;

227.1 (3) not be related as a parent, child, sibling, or spouse to the recipient, qualified
227.2 professional, or the personal care assistant; and
227.3 (4) ensure arm's-length transactions without undue influence or coercion with the
227.4 recipient and personal care assistant.
227.5 (c) The duties of the personal care assistance choice provider agency are to:
227.6 (1) be the employer of the personal care assistant and the qualified professional for
227.7 employment law and related regulations including but not limited to purchasing and
227.8 maintaining workers' compensation, unemployment insurance, surety and fidelity bonds,
227.9 and liability insurance, and submit any or all necessary documentation including, but not
227.10 limited to, workers' compensation and unemployment insurance;
227.11 (2) bill the medical assistance program for personal care assistance services and
227.12 qualified professional services;
227.13 (3) request and complete background studies that comply with the requirements for
227.14 personal care assistants and qualified professionals;
227.15 (4) pay the personal care assistant and qualified professional based on actual hours
227.16 of services provided;
227.17 (5) withhold and pay all applicable federal and state taxes;
227.18 (6) verify and keep records of hours worked by the personal care assistant and
227.19 qualified professional;
227.20 (7) make the arrangements and pay taxes and other benefits, if any; and comply with
227.21 any legal requirements for a Minnesota employer;
227.22 (8) enroll in the medical assistance program as a personal care assistance choice
227.23 agency; and
227.24 (9) enter into a written agreement as specified in subdivision 20 before services
227.25 are provided.
227.26 Subd. 20. **Personal care assistance choice option; administration.** (a) Before
227.27 services commence under the personal care assistance choice option, and annually
227.28 thereafter, the personal care assistance choice provider agency, recipient, or responsible
227.29 party, each personal care assistant, and the qualified professional shall enter into a written
227.30 agreement. The agreement must include at a minimum:
227.31 (1) duties of the recipient, qualified professional, personal care assistant, and
227.32 personal care assistance choice provider agency;
227.33 (2) salary and benefits for the personal care assistant and the qualified professional;
227.34 (3) administrative fee of the personal care assistance choice provider agency and
227.35 services paid for with that fee, including background study fees;
227.36 (4) grievance procedures to respond to complaints;

228.1 (5) procedures for hiring and terminating the personal care assistant; and
228.2 (6) documentation requirements including, but not limited to, time sheets, activity
228.3 records, and the personal care assistance care plan.
228.4 (b) Except for the administrative fee of the personal care assistance choice provider
228.5 agency as reported on the written agreement, the remainder of the rates paid to the
228.6 personal care assistance choice provider agency must be used to pay for the salary and
228.7 benefits for the personal care assistant or the qualified professional. The personal care
228.8 assistance choice provider agency must provide a minimum of 75 percent of the revenue
228.9 generated by the medical assistance rate for personal care assistance for employee
228.10 personal care assistant wages and benefits.
228.11 (c) The commissioner shall deny, revoke, or suspend the authorization to use the
228.12 personal care assistance choice option if:
228.13 (1) it has been determined by the qualified professional or public health nurse that
228.14 the use of this option jeopardizes the recipient's health and safety;
228.15 (2) the parties have failed to comply with the written agreement specified in
228.16 subdivision 20;
228.17 (3) the use of the option has led to abusive or fraudulent billing for personal care
228.18 assistance services; or
228.19 (4) the department terminates the personal care assistance choice option.
228.20 (d) The recipient or responsible party may appeal the commissioner's decision in
228.21 paragraph (c) according to section 256.045. The denial, revocation, or suspension to
228.22 use the personal care assistance choice option must not affect the recipient's authorized
228.23 level of personal care assistance services.
228.24 Subd. 21. **Requirements for initial enrollment of personal care assistance**
228.25 **provider agencies.** (a) All personal care assistance provider agencies must provide, at the
228.26 time of enrollment as a personal care assistance provider agency in a format determined
228.27 by the commissioner, information and documentation that includes, but is not limited to,
228.28 the following:
228.29 (1) the personal care assistance provider agency's current contact information
228.30 including address, telephone number, and e-mail address;
228.31 (2) proof of surety bond coverage in the amount of $50,000 or ten percent of the
228.32 provider's payments from Medicaid in the previous year, whichever is less;
228.33 (3) proof of fidelity bond coverage in the amount of $20,000;
228.34 (4) proof of workers' compensation insurance coverage;

229.1 (5) a description of the personal care assistance provider agency's organization
229.2 identifying the names of all owners, managerial officials, staff, board of directors, and the
229.3 affiliations of the directors, owners, or staff to other service providers;
229.4 (6) a copy of the personal care assistance provider agency's written policies and
229.5 procedures including: hiring of employees; training requirements; service delivery;
229.6 and employee and consumer safety including process for notification and resolution
229.7 of consumer grievances, identification and prevention of communicable diseases, and
229.8 employee misconduct;
229.9 (7) copies of all other forms the personal care assistance provider agency uses in
229.10 the course of daily business including, but not limited to:
229.11 (i) a copy of the personal care assistance provider agency's time sheet if the time
229.12 sheet varies from the standard time sheet for personal care assistance services approved
229.13 by the commissioner, and a letter requesting approval of the personal care assistance
229.14 provider agency's nonstandard time sheet;
229.15 (ii) the personal care assistance provider agency's template for the personal care
229.16 assistance care plan; and
229.17 (iii) the personal care assistance provider agency's template and the written
229.18 agreement in subdivision 20 for recipients using the personal care assistance choice
229.19 option, if applicable;
229.20 (8) a list of all trainings and classes that the personal care assistance provider agency
229.21 requires of its staff providing personal care assistance services;
229.22 (9) documentation that the personal care assistance provider agency and staff have
229.23 successfully completed all the training required by this section;
229.24 (10) disclosure of ownership, leasing, or management of all residential properties
229.25 that is used or could be used for providing home care services;
229.26 (11) documentation of the agency's marketing practices; and
229.27 (12) documentation that the agency will provide 75 percent for the personal care
229.28 assistance choice provider agency and 65 percent for regular personal care assistance
229.29 agency, or revenue generated from the medical assistance rate paid for personal care
229.30 assistance services for employee personal care assistant wages and benefits.
229.31 (b) Personal care assistance provider agencies shall provide the information specified
229.32 in paragraph (a) to the commissioner at the time the personal care assistance provider
229.33 agency enrolls as a vendor or upon request from the commissioner. The commissioner
229.34 shall collect the information specified in paragraph (a) from all personal care assistance
229.35 providers beginning upon enactment of this section.

230.1 (c) All personal care assistance provider agencies shall complete mandatory training
230.2 as determined by the commissioner before enrollment as a provider. Personal care
230.3 assistance provider agencies are required to send all owners employed by the agency
230.4 and all other managerial officials to the initial and subsequent trainings. Personal care
230.5 assistance provider agency billing staff shall complete training about personal care
230.6 assistance program financial management. This training is effective upon enactment of
230.7 this section. Any personal care assistance provider agency enrolled before that date shall,
230.8 if it has not already, complete the provider training within 18 months of the effective
230.9 date of this section. Any new owners, new qualified professionals, and new managerial
230.10 officials are required to complete mandatory training as a requisite of hiring.

230.11 Subd. 22. **Annual review for personal care providers.** (a) All personal care
230.12 assistance provider agencies shall resubmit, on an annual basis, the information specified
230.13 in subdivision 21, in a format determined by the commissioner, and provide a copy of the
230.14 personal care assistance provider agency's most current version of its grievance policies
230.15 and procedures along with a written record of grievances and resolutions of the grievances
230.16 that the personal care assistance provider agency has received in the previous year and any
230.17 other information requested by the commissioner.

230.18 (b) The commissioner shall send annual review notification to personal care
230.19 assistance provider agencies 30 days prior to renewal. The notification must:

230.20 (1) list the materials and information the personal care assistance provider agency is
230.21 required to submit;

230.22 (2) provide instructions on submitting information to the commissioner; and

230.23 (3) provide a due date by which the commissioner must receive the requested
230.24 information.

230.25 Personal care assistance provider agencies shall submit required documentation for
230.26 annual review within 30 days of notification from the commissioner. If no documentation
230.27 is submitted, the personal care assistance provider agency enrollment number must be
230.28 terminated or suspended.

230.29 (c) Personal care assistance provider agencies also currently licensed under
230.30 Minnesota Rules, part 4668.0012, as a class A provider or currently certified for
230.31 participation in Medicare as a home health agency under Code of Federal Regulations,
230.32 title 42, part 484, are deemed in compliance with the personal care assistance requirements
230.33 for enrollment, annual review process, and documentation.

230.34 Subd. 23. **Enrollment requirements following termination.** (a) A terminated
230.35 personal care assistance provider agency, including all named individuals on the current
230.36 enrollment disclosure form and known or discovered affiliates of the personal care

231.1 assistance provider agency, is not eligible to enroll as a personal care assistance provider
231.2 agency for two years following the termination.

231.3 (b) After the two-year period in paragraph (a), if the provider seeks to reenroll
231.4 as a personal care assistance provider agency, the personal care assistance provider
231.5 agency must be placed on a one-year probation period, beginning after completion of
231.6 the following:

231.7 (1) the department's provider trainings under this section; and

231.8 (2) initial enrollment requirements under subdivision 21.

231.9 (c) During the probationary period the commissioner shall complete site visits and
231.10 request submission of documentation to review compliance with program policies.

231.11 Subd. 24. **Personal care assistance provider agency; general duties.** A personal
231.12 care assistance provider agency shall:

231.13 (1) enroll as a Medicaid provider meeting all provider standards, including
231.14 completion of the required provider training;

231.15 (2) comply with general medical assistance coverage requirements;

231.16 (3) demonstrate compliance with law and policies of the personal care assistance
231.17 program to be determined by the commissioner;

231.18 (4) comply with background study requirements;

231.19 (5) verify and keep records of hours worked by the personal care assistant and
231.20 qualified professional;

231.21 (6) pay the personal care assistant or qualified professional based on actual hours of
231.22 services provided;

231.23 (7) document that the agency uses a minimum of 75 percent of the revenue generated
231.24 from the medical assistance rate for personal care assistant services for employee personal
231.25 care assistant wages and benefits;

231.26 (8) withhold and pay all applicable federal and state taxes;

231.27 (9) make the arrangements and pay unemployment insurance, taxes, workers'
231.28 compensation, liability insurance, and other benefits, if any;

231.29 (10) enter into a written agreement under subdivision 21 before services are
231.30 provided;

231.31 (11) report suspected neglect and abuse to the common entry point according to
231.32 section 256B.0651;

231.33 (12) provide the recipient with a copy of the home care bill of rights at start of
231.34 service;

232.1 (13) market agency services only through printed information in brochures and on
232.2 Web sites and not engage in any direct contact or marketing in person, by telephone, or
232.3 other electronic means to potential recipients, guardians, or family members; and
232.4 (14) request reassessments at least 60 days prior to the end of the current
232.5 authorization for personal care assistant services on forms provided by the commissioner.
232.6 Subd. 25. **Personal care assistance provider agency; background studies.**
232.7 Personal care assistance provider agencies enrolled to provide personal care assistance
232.8 services under the medical assistance program shall comply with the following:
232.9 (1) owners who have a five percent interest or more and all managerial officials are
232.10 subject to a background study as provided in chapter 245C. This applies to currently
232.11 enrolled personal care assistance provider agencies and those agencies seeking enrollment
232.12 as a personal care assistance provider agency. Managerial official has the same meaning
232.13 as Code of Federal Regulations, title 42, section 455. An organization is barred from
232.14 enrollment if:
232.15 (i) the organization has not initiated background studies on owners and managerial
232.16 officials; or
232.17 (ii) the organization has initiated background studies on owners and managerial
232.18 officials, but the commissioner has sent the organization a notice that an owner or
232.19 managerial official of the organization has been disqualified under section 245C.14,
232.20 and the owner or managerial official has not received a set aside of the disqualification
232.21 under section 245C.22;
232.22 (2) a background study must be initiated and completed for all qualified
232.23 professionals; and
232.24 (3) a background study must be initiated and completed for all personal care
232.25 assistants.
232.26 Subd. 26. **Personal care assistance provider agency; communicable disease**
232.27 **prevention.** A personal care assistance provider agency shall establish and implement
232.28 policies and procedures for prevention, control, and investigation of infections and
232.29 communicable diseases according to current nationally recognized infection control
232.30 practices or guidelines established by the United States Centers for Disease Control and
232.31 Prevention, as well as applicable regulations of other federal or state agencies.
232.32 Subd. 27. **Personal care assistance provider agency; ventilator training.** The
232.33 personal care assistance provider agency is required to provide training for the personal
232.34 care assistant responsible for working with a recipient who is ventilator dependent. All
232.35 training must be administered by a respiratory therapist, nurse, or physician. Qualified
232.36 professional supervision by a nurse must be completed and documented on file in the

233.1 personal care assistant's employment record and the recipient's health record. If offering
233.2 personal care services to a ventilator-dependent recipient, the personal care assistance
233.3 provider agency shall demonstrate the ability to:

233.4 (1) train the personal care assistant;

233.5 (2) supervise the personal care assistant in ventilator operation and maintenance; and

233.6 (3) supervise the recipient and responsible party in ventilator operation and
233.7 maintenance.

233.8 Subd. 28. **Personal care assistance provider agency; required documentation.**
233.9 Required documentation must be completed and kept in the personal care assistance
233.10 provider agency file or the recipient's home residence. The required documentation
233.11 consists of:

233.12 (1) employee files, including:

233.13 (i) applications for employment;

233.14 (ii) background study requests and results;

233.15 (iii) orientation records about the agency policies;

233.16 (iv) trainings completed with demonstration of competence;

233.17 (v) supervisory visits;

233.18 (vi) evaluations of employment; and

233.19 (vii) signature on fraud statement;

233.20 (2) recipient files, including:

233.21 (i) demographics;

233.22 (ii) emergency contact information and emergency backup plan;

233.23 (iii) personal care assistance service plan;

233.24 (iv) personal care assistance care plan;

233.25 (v) month-to-month service use plan;

233.26 (vi) all communication records;

233.27 (vii) start of service information, including the written agreement with recipient; and

233.28 (viii) date the home care bill of rights was given to the recipient;

233.29 (3) agency policy manual, including:

233.30 (i) policies for employment and termination;

233.31 (ii) grievance policies with resolution of consumer grievances;

233.32 (iii) staff and consumer safety;

233.33 (iv) staff misconduct; and

233.34 (v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and
233.35 resolution of consumer grievances; and

234.1 (4) time sheets for each personal care assistant along with completed activity sheets
234.2 for each recipient served.
234.3 Subd. 29. **Transitional assistance.** Notwithstanding any contrary provision in
234.4 this section, the commissioner, counties, and personal care assistance providers shall
234.5 work together to provide transitional assistance for recipients and families to come into
234.6 compliance with the requirements of this section, and ensure that personal care assistance
234.7 services are not provided by the housing provider. The commissioner and counties shall
234.8 provide this assistance until July 1, 2010.
234.9 Subd. 30. **Notice of service changes to recipients.** All recipients who will be
234.10 affected by the changes in medical assistance home care services must be provided notice
234.11 of the changes at least 30 days before the effective date of the change. The notice shall
234.12 include how to get further information on the changes, how to get help to obtain other
234.13 services, a list of community resources, and appeal rights. Notwithstanding section
234.14 256.045, a recipient may request continued services pending appeal within the time period
234.15 allowed to request an appeal.

234.16 Sec. 34. Minnesota Statutes 2008, section 256B.0911, subdivision 1, is amended to
234.17 read:
234.18 Subdivision 1. **Purpose and goal.** (a) The purpose of long-term care consultation
234.19 services is to assist persons with long-term or chronic care needs in making long-term
234.20 care decisions and selecting options that meet their needs and reflect their preferences.
234.21 The availability of, and access to, information and other types of assistance, including
234.22 assessment and support planning, is also intended to prevent or delay certified nursing
234.23 facility placements and to provide transition assistance after admission. Further, the goal
234.24 of these services is to contain costs associated with unnecessary certified nursing facility
234.25 admissions. Long-term consultation services must be available to any person regardless
234.26 of public program eligibility. The ~~commissioners~~ commissioner of human services ~~and~~
234.27 ~~health~~ shall seek to maximize use of available federal and state funds and establish the
234.28 broadest program possible within the funding available.
234.29 (b) These services must be coordinated with ~~services~~ long-term care options
234.30 counseling provided under section 256.975, subdivision 7, and ~~with services provided by~~
234.31 ~~other public and private agencies in the community~~ section 256.01, subdivision 24, for
234.32 telephone assistance and follow up and to offer a variety of cost-effective alternatives to
234.33 persons with disabilities and elderly persons. The county or tribal agency or managed
234.34 care plan providing long-term care consultation services shall encourage the use of

235.1 volunteers from families, religious organizations, social clubs, and similar civic and
235.2 service organizations to provide community-based services.

235.3 Sec. 35. Minnesota Statutes 2008, section 256B.0911, subdivision 1a, is amended to
235.4 read:

235.5 Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:
235.6 (a) "Long-term care consultation services" means:
235.7 ~~(1) providing information and education to the general public regarding availability~~
235.8 ~~of the services authorized under this section;~~
235.9 ~~(2) an intake process that provides access to the services described in this section;~~
235.10 ~~(3) assessment of the health, psychological, and social needs of referred individuals;~~
235.11 ~~(4)~~ (1) assistance in identifying services needed to maintain an individual in the
235.12 ~~least restrictive~~ most inclusive environment;
235.13 ~~(5)~~ (2) providing recommendations on cost-effective community services that are
235.14 available to the individual;
235.15 ~~(6)~~ (3) development of an individual's person-centered community support plan;
235.16 ~~(7)~~ (4) providing information regarding eligibility for Minnesota health care
235.17 programs;
235.18 (5) face-to-face long-term care consultation assessments, which may be completed
235.19 in a hospital, nursing facility, intermediate care facility for persons with developmental
235.20 disabilities (ICF/DDs), regional treatment centers, or the person's current or planned
235.21 residence;
235.22 ~~(8) preadmission~~ (6) federally mandated screening to determine the need for
235.23 a ~~nursing facility~~ institutional level of care under section 256B.0911, subdivision 4,
235.24 paragraph (a);
235.25 ~~(9) preliminary~~ (7) determination of ~~Minnesota health care programs~~ home and
235.26 community-based waiver service eligibility including level of care determination for
235.27 individuals who need ~~a nursing facility~~ an institutional level of care as defined under
235.28 section 144.0724, subdivision 11, or 256B.092, service eligibility including state plan
235.29 home care services identified in section 256B.0625, subdivisions 6, 7, and 19, paragraphs
235.30 (a) and (c), based on assessment and support plan development with appropriate referrals
235.31 ~~for final determination~~;
235.32 ~~(10)~~ (8) providing recommendations for nursing facility placement when there are
235.33 no cost-effective community services available; and
235.34 ~~(11)~~ (9) assistance to transition people back to community settings after facility
235.35 admission.

236.1 (b) "Long-term care options counseling" means the services provided by the linkage
236.2 lines as mandated by sections 256.01 and 256.975, subdivision 7.
236.3 ~~(b)~~ (c) "Minnesota health care programs" means the medical assistance program
236.4 under chapter 256B and the alternative care program under section 256B.0913.
236.5 (d) "Lead agencies" means counties or a collaboration of counties, tribes, and health
236.6 plans administering long-term care consultation assessment and support planning services.

236.7 **EFFECTIVE DATE.** The amendment to paragraph (a), clause (7), replacing a
236.8 reference to nursing facility level of care with institutional level of care as defined under
236.9 Minnesota Statutes, section 144.0724, subdivision 11, or 256B.092, is effective July 1,
236.10 2011.

236.11 Sec. 36. Minnesota Statutes 2008, section 256B.0911, is amended by adding a
236.12 subdivision to read:
236.13 Subd. 2b. **Certified assessors.** (a) Beginning January 1, 2011, each lead agency
236.14 shall have certified assessors who have completed training and certification process
236.15 determined by the commissioner in subdivision 2c. Certified assessors shall demonstrate
236.16 best practices in assessment and support planning including person-centered planning
236.17 principals and have a common set of skills that must ensure consistency and equitable
236.18 access to services statewide.
236.19 (b) Certified assessors are persons with a minimum of a bachelor's degree in social
236.20 work, nursing with a public health nursing certificate, or other closely related field with at
236.21 least one year of home and community-based experience or a two-year registered nursing
236.22 degree with at least three years of home and community-based experience that have
236.23 received training and certification specific to assessment and consultation for long-term
236.24 care services in the state.

236.25 Sec. 37. Minnesota Statutes 2008, section 256B.0911, is amended by adding a
236.26 subdivision to read:
236.27 Subd. 2c. **Assessor training and certification.** The commissioner shall develop
236.28 curriculum and a certification process to begin no later than January 1, 2010. All existing
236.29 lead agency staff designated to provide the services defined in subdivision 1a must be
236.30 certified by December 30, 2010. Each lead agency is required to ensure that they have
236.31 sufficient numbers of certified assessors to provide long-term consultation assessment and
236.32 support planning within the timelines and parameters of the service by January 1, 2011.
236.33 Certified assessors are required to be recertified every three years.

237.1 Sec. 38. Minnesota Statutes 2008, section 256B.0911, subdivision 3, is amended to
237.2 read:

237.3 Subd. 3. **Long-term care consultation team.** (a) Until January 1, 2011, a long-term
237.4 care consultation team shall be established by the county board of commissioners. Each
237.5 local consultation team shall consist of at least one social worker and at least one public
237.6 health nurse from their respective county agencies. The board may designate public
237.7 health or social services as the lead agency for long-term care consultation services. If a
237.8 county does not have a public health nurse available, it may request approval from the
237.9 commissioner to assign a county registered nurse with at least one year experience in
237.10 home care to participate on the team. Two or more counties may collaborate to establish
237.11 a joint local consultation team or teams.

237.12 (b) The team is responsible for providing long-term care consultation services to
237.13 all persons located in the county who request the services, regardless of eligibility for
237.14 Minnesota health care programs.

237.15 (c) The commissioner shall allow arrangements and make recommendations that
237.16 encourage counties to collaborate to establish joint local long-term care consultation
237.17 teams to ensure that long-term care consultations are done within the timelines and
237.18 parameters of the service. This includes integrated service models as required in section
237.19 256B.0911, subdivision 1, paragraph (b).

237.20 Sec. 39. Minnesota Statutes 2008, section 256B.0911, subdivision 3a, is amended to
237.21 read:

237.22 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment,
237.23 services planning, or other assistance intended to support community-based living,
237.24 including persons who need assessment in order to determine personal care assistance
237.25 services, private duty nursing services, home health agency services, waiver or alternative
237.26 care program eligibility, must be visited by a long-term care consultation team or after
237.27 January 1, 2011, a certified assessor within ~~ten working~~ 20 working days after the date on
237.28 which an assessment was requested or recommended. Face-to-face assessments must be
237.29 conducted according to paragraphs (b) to ~~(i)~~ (k).

237.30 (b) The county may utilize a team of either the social worker or public health nurse,
237.31 or both, after January 1, 2011, lead agencies shall use a certified assessor to conduct the
237.32 assessment in a face-to-face interview. The consultation team members must confer
237.33 regarding the most appropriate care for each individual screened or assessed.

237.34 (c) The ~~long-term care consultation team must assess the health and social needs of~~
237.35 ~~the person~~ assessment must be comprehensive and include a person-centered assessment

238.1 of the health, psychological, functional, environmental, and social needs of referred
238.2 individuals and provide information necessary to develop a support plan that meets the
238.3 consumers needs, using an assessment form provided by the commissioner.

238.4 (d) The team must conduct the assessment must be conducted in a face-to-face
238.5 interview with the person being assessed and the person's legal representative, if applicable
238.6 as required by legally executed documents, and other individuals as requested by the
238.7 person, who can provide information on the needs, strengths, and preferences of the
238.8 person necessary to develop a support plan that ensures the person's health and safety, but
238.9 who is not a provider of service or has any financial interest in the provision of services.

238.10 (e) The team must provide the person, or the person's legal representative, must
238.11 be provided with written recommendations for facility- or community-based services.
238.12 The team must document or institutional care that include documentation that the most
238.13 cost-effective alternatives available were offered to the individual. For purposes of
238.14 this requirement, "cost-effective alternatives" means community services and living
238.15 arrangements that cost the same as or less than nursing facility institutional care.

238.16 (f) If the person chooses to use community-based services, the team must provide
238.17 the person or the person's legal representative must be provided with a written community
238.18 support plan, regardless of whether the individual is eligible for Minnesota health care
238.19 programs. The A person may request assistance in developing a community support plan
238.20 identifying community supports without participating in a complete assessment. Upon
238.21 a request for assistance identifying community support, the person must be transferred
238.22 or referred to the services available under sections 256.975, subdivision 7, and 256.01,
238.23 subdivision 24, for telephone assistance and follow up.

238.24 (g) The person has the right to make the final decision between nursing
238.25 facility institutional placement and community placement after the screening team's
238.26 recommendation recommendations have been provided, except as provided in subdivision
238.27 4a, paragraph (c).

238.28 (h) The team must give the person receiving assessment or support planning, or
238.29 the person's legal representative, materials, and forms supplied by the commissioner
238.30 containing the following information:

238.31 (1) the need for and purpose of preadmission screening if the person selects nursing
238.32 facility placement;

238.33 (2) the role of the long-term care consultation assessment and support planning in
238.34 waiver and alternative care program eligibility determination;

238.35 (3) information about Minnesota health care programs;

238.36 (4) the person's freedom to accept or reject the recommendations of the team;

239.1 (5) the person's right to confidentiality under the Minnesota Government Data
239.2 Practices Act, chapter 13;
239.3 (6) the long-term care consultant's decision regarding the person's need for ~~nursing~~
239.4 ~~facility~~ institutional level of care as determined under criteria established in section
239.5 144.0724, subdivision 11, or 256B.092; and
239.6 (7) the person's right to appeal the decision regarding the need for nursing facility
239.7 level of care or the county's final decisions regarding public programs eligibility according
239.8 to section 256.045, subdivision 3.
239.9 (i) Face-to-face assessment completed as part of eligibility determination for
239.10 the alternative care, elderly waiver, community alternatives for disabled individuals,
239.11 community alternative care, and traumatic brain injury waiver programs under sections
239.12 256B.0915, 256B.0917, and 256B.49 is valid to establish service eligibility for no more
239.13 than 60 calendar days after the date of assessment. The effective eligibility start date
239.14 for these programs can never be prior to the date of assessment. If an assessment was
239.15 completed more than 60 days before the effective waiver or alternative care program
239.16 eligibility start date, assessment and support plan information must be updated in a
239.17 face-to-face visit and documented in the department's Medicaid Management Information
239.18 System (MMIS). The effective date of program eligibility in this case cannot be prior to
239.19 the date the updated assessment is completed.

239.20 **EFFECTIVE DATE.** The amendment to paragraph (h), clause (6), is effective
239.21 July 1, 2011.

239.22 Sec. 40. Minnesota Statutes 2008, section 256B.0911, subdivision 4a, is amended to
239.23 read:
239.24 Subd. 4a. **Preadmission screening activities related to nursing facility**
239.25 **admissions.** (a) All applicants to Medicaid certified nursing facilities, including certified
239.26 boarding care facilities, must be screened prior to admission regardless of income, assets,
239.27 or funding sources for nursing facility care, except as described in subdivision 4b. The
239.28 purpose of the screening is to determine the need for nursing facility level of care as
239.29 described in paragraph (d) and to complete activities required under federal law related to
239.30 mental illness and developmental disability as outlined in paragraph (b).
239.31 (b) A person who has a diagnosis or possible diagnosis of mental illness or
239.32 developmental disability must receive a preadmission screening before admission
239.33 regardless of the exemptions outlined in subdivision 4b, paragraph (b), to identify the need
239.34 for further evaluation and specialized services, unless the admission prior to screening is

240.1 authorized by the local mental health authority or the local developmental disabilities case
240.2 manager, or unless authorized by the county agency according to Public Law 101-508.
240.3 The following criteria apply to the preadmission screening:
240.4 (1) the county must use forms and criteria developed by the commissioner to identify
240.5 persons who require referral for further evaluation and determination of the need for
240.6 specialized services; and
240.7 (2) the evaluation and determination of the need for specialized services must be
240.8 done by:
240.9 (i) a qualified independent mental health professional, for persons with a primary or
240.10 secondary diagnosis of a serious mental illness; or
240.11 (ii) a qualified developmental disability professional, for persons with a primary or
240.12 secondary diagnosis of developmental disability. For purposes of this requirement, a
240.13 qualified developmental disability professional must meet the standards for a qualified
240.14 developmental disability professional under Code of Federal Regulations, title 42, section
240.15 483.430.
240.16 (c) The local county mental health authority or the state developmental disability
240.17 authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a
240.18 nursing facility if the individual does not meet the nursing facility level of care criteria or
240.19 needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For
240.20 purposes of this section, "specialized services" for a person with developmental disability
240.21 means active treatment as that term is defined under Code of Federal Regulations, title
240.22 42, section 483.440 (a)(1).
240.23 (d) The determination of the need for nursing facility level of care must be made
240.24 according to criteria established in section 144.0724, subdivision 11, and 256B.092,
240.25 using forms developed by the commissioner. In assessing a person's needs, consultation
240.26 team members shall have a physician available for consultation and shall consider the
240.27 assessment of the individual's attending physician, if any. The individual's physician must
240.28 be included if the physician chooses to participate. Other personnel may be included on
240.29 the team as deemed appropriate by the county.

240.30 **EFFECTIVE DATE.** The section is effective July 1, 2011.

240.31 Sec. 41. Minnesota Statutes 2008, section 256B.0911, subdivision 5, is amended to
240.32 read:
240.33 Subd. 5. **Administrative activity.** The commissioner shall minimize the number
240.34 of ~~forms required in the provision of long-term care consultation services and shall~~
240.35 ~~limit the screening document to items necessary for community support plan approval,~~

241.1 ~~reimbursement, program planning, evaluation, and policy development~~ business processes
241.2 required to provide the services in this section and shall implement integrated solutions
241.3 to automate the business processes to the extent necessary for community support plan
241.4 approval, reimbursement, program planning, evaluation, and policy development.

241.5 Sec. 42. Minnesota Statutes 2008, section 256B.0911, subdivision 6, is amended to
241.6 read:

241.7 Subd. 6. **Payment for long-term care consultation services.** (a) The total payment
241.8 for each county must be paid monthly by certified nursing facilities in the county. The
241.9 monthly amount to be paid by each nursing facility for each fiscal year must be determined
241.10 by dividing the county's annual allocation for long-term care consultation services by 12
241.11 to determine the monthly payment and allocating the monthly payment to each nursing
241.12 facility based on the number of licensed beds in the nursing facility. Payments to counties
241.13 in which there is no certified nursing facility must be made by increasing the payment
241.14 rate of the two facilities located nearest to the county seat.

241.15 (b) The commissioner shall include the total annual payment determined under
241.16 paragraph (a) for each nursing facility reimbursed under section 256B.431 or 256B.434
241.17 according to section 256B.431, subdivision 2b, paragraph (g).

241.18 (c) In the event of the layaway, delicensure and decertification, or removal from
241.19 layaway of 25 percent or more of the beds in a facility, the commissioner may adjust
241.20 the per diem payment amount in paragraph (b) and may adjust the monthly payment
241.21 amount in paragraph (a). The effective date of an adjustment made under this paragraph
241.22 shall be on or after the first day of the month following the effective date of the layaway,
241.23 delicensure and decertification, or removal from layaway.

241.24 (d) Payments for long-term care consultation services are available to the county
241.25 or counties to cover staff salaries and expenses to provide the services described in
241.26 subdivision 1a. The county shall employ, or contract with other agencies to employ, within
241.27 the limits of available funding, sufficient personnel to provide long-term care consultation
241.28 services while meeting the state's long-term care outcomes and objectives as defined in
241.29 section 256B.0917, subdivision 1. The county shall be accountable for meeting local
241.30 objectives as approved by the commissioner in the biennial home and community-based
241.31 services quality assurance plan on a form provided by the commissioner.

241.32 (e) Notwithstanding section 256B.0641, overpayments attributable to payment of the
241.33 screening costs under the medical assistance program may not be recovered from a facility.

241.34 (f) The commissioner of human services shall amend the Minnesota medical
241.35 assistance plan to include reimbursement for the local consultation teams.

(g) The county may bill, as case management services, assessments, support planning, and follow-along provided to persons determined to be eligible for case management under Minnesota health care programs. No individual or family member shall be charged for an initial assessment or initial support plan development provided under subdivision 3a or 3b.

(h) The commissioner shall develop an alternative payment methodology for long-term care consultation services that includes the funding available under this subdivision, and sections 256B.092 and 256B.0655. In developing the new payment methodology, the commissioner shall consider the maximization of federal funding for this activity.

Sec. 43. Minnesota Statutes 2008, section 256B.0911, subdivision 7, is amended to read:

Subd. 7. **Reimbursement for certified nursing facilities.** (a) Medical assistance reimbursement for nursing facilities shall be authorized for a medical assistance recipient only if a preadmission screening has been conducted prior to admission or the county has authorized an exemption. Medical assistance reimbursement for nursing facilities shall not be provided for any recipient who the local screener has determined does not meet the level of care criteria for nursing facility placement in section 144.0724, subdivision 11, or, if indicated, has not had a level II OBRA evaluation as required under the federal Omnibus Budget Reconciliation Act of 1987 completed unless an admission for a recipient with mental illness is approved by the local mental health authority or an admission for a recipient with developmental disability is approved by the state developmental disability authority.

(b) The nursing facility must not bill a person who is not a medical assistance recipient for resident days that preceded the date of completion of screening activities as required under subdivisions 4a, 4b, and 4c. The nursing facility must include unreimbursed resident days in the nursing facility resident day totals reported to the commissioner.

EFFECTIVE DATE. The section is effective July 1, 2011.

Sec. 44. Minnesota Statutes 2008, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.** (a) Funding for services under the alternative care program is available to persons who meet the following criteria:

243.1 (1) the person has been determined by a community assessment under section
243.2 256B.0911 to be a person who would require the level of care provided in a nursing
243.3 facility according to the criteria established in section 144.0724, subdivision 11, but for
243.4 the provision of services under the alternative care program;
243.5 (2) the person is age 65 or older;
243.6 (3) the person would be eligible for medical assistance within 135 days of admission
243.7 to a nursing facility;
243.8 (4) the person is not ineligible for the payment of long-term care services by the
243.9 medical assistance program due to an asset transfer penalty under section 256B.0595 or
243.10 equity interest in the home exceeding $500,000 as stated in section 256B.056;
243.11 (5) the person needs long-term care services that are not funded through other state
243.12 or federal funding;
243.13 (6) the monthly cost of the alternative care services funded by the program for
243.14 this person does not exceed 75 percent of the monthly limit described under section
243.15 256B.0915, subdivision 3a. This monthly limit does not prohibit the alternative care
243.16 client from payment for additional services, but in no case may the cost of additional
243.17 services purchased under this section exceed the difference between the client's monthly
243.18 service limit defined under section 256B.0915, subdivision 3, and the alternative care
243.19 program monthly service limit defined in this paragraph. If care-related supplies and
243.20 equipment or environmental modifications and adaptations are or will be purchased for
243.21 an alternative care services recipient, the costs may be prorated on a monthly basis for
243.22 up to 12 consecutive months beginning with the month of purchase. If the monthly cost
243.23 of a recipient's other alternative care services exceeds the monthly limit established in
243.24 this paragraph, the annual cost of the alternative care services shall be determined. In this
243.25 event, the annual cost of alternative care services shall not exceed 12 times the monthly
243.26 limit described in this paragraph; and
243.27 (7) the person is making timely payments of the assessed monthly fee.
243.28 A person is ineligible if payment of the fee is over 60 days past due, unless the person
243.29 agrees to:
243.30 (i) the appointment of a representative payee;
243.31 (ii) automatic payment from a financial account;
243.32 (iii) the establishment of greater family involvement in the financial management of
243.33 payments; or
243.34 (iv) another method acceptable to the lead agency to ensure prompt fee payments.
243.35 The lead agency may extend the client's eligibility as necessary while making
243.36 arrangements to facilitate payment of past-due amounts and future premium payments.

244.1 Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be
244.2 reinstated for a period of 30 days.
244.3 (b) Alternative care funding under this subdivision is not available for a person
244.4 who is a medical assistance recipient or who would be eligible for medical assistance
244.5 without a spenddown or waiver obligation. A person whose initial application for medical
244.6 assistance and the elderly waiver program is being processed may be served under the
244.7 alternative care program for a period up to 60 days. If the individual is found to be eligible
244.8 for medical assistance, medical assistance must be billed for services payable under the
244.9 federally approved elderly waiver plan and delivered from the date the individual was
244.10 found eligible for the federally approved elderly waiver plan. Notwithstanding this
244.11 provision, alternative care funds may not be used to pay for any service the cost of which:
244.12 (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation;
244.13 or (iii) is used to pay a medical assistance income spenddown for a person who is eligible
244.14 to participate in the federally approved elderly waiver program under the special income
244.15 standard provision.
244.16 (c) Alternative care funding is not available for a person who resides in a licensed
244.17 nursing home, certified boarding care home, hospital, or intermediate care facility, except
244.18 for case management services which are provided in support of the discharge planning
244.19 process for a nursing home resident or certified boarding care home resident to assist with
244.20 a relocation process to a community-based setting.
244.21 (d) Alternative care funding is not available for a person whose income is greater
244.22 than the maintenance needs allowance under section 256B.0915, subdivision 1d, but equal
244.23 to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal
244.24 year for which alternative care eligibility is determined, who would be eligible for the
244.25 elderly waiver with a waiver obligation.

244.26 **EFFECTIVE DATE.** The section is effective July 1, 2011.

244.27 Sec. 45. Minnesota Statutes 2008, section 256B.0915, subdivision 3e, is amended to
244.28 read:
244.29 Subd. 3e. **Customized living service rate.** (a) Payment for customized living
244.30 services shall be a monthly rate ~~negotiated and~~ authorized by the lead agency within the
244.31 parameters established by the commissioner. The payment agreement must delineate the
244.32 ~~services that have been customized for each recipient and specify the~~ amount of each
244.33 component service included in the recipient's customized living service ~~to be provided~~
244.34 plan. The lead agency shall ensure that there is a documented need ~~for all~~ within the

245.1 parameters established by the commissioner for all component customized living services
245.2 authorized. ~~Customized living services must not include rent or raw food costs.~~
245.3 (b) The ~~negotiated~~ payment rate must be based on the amount of component services
245.4 to be provided utilizing component rates established by the commissioner. Counties and
245.5 tribes shall use tools issued by the commissioner to develop and document customized
245.6 living service plans and rates.
245.7 ~~Negotiated~~ (c) Component service rates must not exceed payment rates for
245.8 comparable elderly waiver or medical assistance services and must reflect economies of
245.9 scale. Customized living services must not include rent or raw food costs.
245.10 ~~(b)~~ (d) The individualized monthly ~~negotiated~~ authorized payment for the
245.11 customized living ~~services~~ service plan shall not exceed ~~the nonfederal share, in effect~~
245.12 ~~on July 1 of the state fiscal year for which the rate limit is being calculated,~~ 50 percent
245.13 of the greater of either the statewide or any of the geographic groups' weighted average
245.14 monthly nursing facility rate of the case mix resident class to which the elderly waiver
245.15 eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059,
245.16 less the maintenance needs allowance as described in subdivision 1d, paragraph (a), until
245.17 the July 1 of the state fiscal year in which the resident assessment system as described
245.18 in section 256B.438 for nursing home rate determination is implemented. Effective on
245.19 July 1 of the state fiscal year in which the resident assessment system as described in
245.20 section 256B.438 for nursing home rate determination is implemented and July 1 of each
245.21 subsequent state fiscal year, the individualized monthly ~~negotiated~~ authorized payment
245.22 for the services described in this clause shall not exceed the limit ~~described in this clause~~
245.23 which was in effect on June 30 of the previous state fiscal year ~~and which has been~~
245.24 ~~adjusted by the greater of any legislatively adopted home and community-based services~~
245.25 ~~cost-of-living percentage increase or any legislatively adopted statewide percent rate~~
245.26 ~~increase for nursing facilities~~ updated annually based on legislatively adopted changes to
245.27 all service rate maximums for home and community-based service providers.
245.28 ~~(c)~~ (e) Customized living services are delivered by a provider licensed by the
245.29 Department of Health as a class A or class F home care provider and provided in a
245.30 building that is registered as a housing with services establishment under chapter 144D.

245.31 Sec. 46. Minnesota Statutes 2008, section 256B.0915, subdivision 3h, is amended to
245.32 read:
245.33 Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The
245.34 payment rates for 24-hour customized living services ~~is~~ are a monthly rate ~~negotiated and~~
245.35 authorized by the lead agency within the parameters established by the commissioner

246.1 of human services. The payment agreement must delineate the ~~services that have been~~
246.2 ~~customized for each recipient and specify the~~ amount of each component service included
246.3 in each recipient's customized living service ~~to be provided~~ plan. The lead agency
246.4 shall ensure that there is a documented need within the parameters established by the
246.5 commissioner for all component customized living services authorized. The lead agency
246.6 shall not authorize 24-hour customized living services unless there is a documented need
246.7 for 24-hour supervision.
246.8 (b) For purposes of this section, "24-hour supervision" means that the recipient
246.9 requires assistance due to needs related to one or more of the following:
246.10 (1) intermittent assistance with toileting or transferring;
246.11 (2) cognitive or behavioral issues;
246.12 (3) a medical condition that requires clinical monitoring; or
246.13 (4) other conditions or needs as defined by the commissioner of human services.
246.14 The lead agency shall ensure that the frequency and mode of supervision of the recipient
246.15 and the qualifications of staff providing supervision are described and meet the needs of
246.16 the recipient. ~~Customized living services must not include rent or raw food costs.~~
246.17 (c) The ~~negotiated~~ payment rate for 24-hour customized living services must be
246.18 based on the amount of component services to be provided utilizing component rates
246.19 established by the commissioner. Counties and tribes will use tools issued by the
246.20 commissioner to develop and document customized living plans and authorize rates.
246.21 ~~Negotiated~~ (d) Component service rates must not exceed payment rates for
246.22 comparable elderly waiver or medical assistance services and must reflect economies
246.23 of scale.
246.24 (e) The individually ~~negotiated~~ authorized 24-hour customized living payments,
246.25 in combination with the payment for other elderly waiver services, including case
246.26 management, must not exceed the recipient's community budget cap specified in
246.27 subdivision 3a. Customized living services must not include rent or raw food costs.
246.28 (f) The individually authorized 24-hour customized living payment rates shall not
246.29 exceed the 95 percentile of statewide monthly authorizations for 24-hour customized
246.30 living services in effect and in the Medicaid management information systems on March
246.31 31, 2009, for each case mix resident class under Minnesota Rules, parts 9549.0050
246.32 to 9549.0059, to which elderly waiver service clients are assigned. When there are
246.33 fewer than 50 authorizations in effect in the case mix resident class, the commissioner
246.34 shall multiply the calculated service payment rate maximum for the A classification by
246.35 the standard weight for that classification under Minnesota Rules, parts 9549.0050 to
246.36 9549.0059, to determine the applicable payment rate maximum. Service payment rate

247.1 maximums shall be updated annually based on legislatively adopted changes to all service
247.2 rates for home and community-based service providers.
247.3 (g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner
247.4 may establish alternative payment rate systems for 24-hour customized living services in
247.5 housing with services establishments which are freestanding buildings with a capacity of
247.6 16 or fewer, by applying a single hourly rate for covered component services provided
247.7 in either:
247.8 (1) licensed corporate adult foster homes; or
247.9 (2) specialized dementia care units which meet the requirements of section 144D.065
247.10 and in which:
247.11 (i) each resident is offered the option of having their own apartment; or
247.12 (ii) the units are licensed as board and lodge establishments with maximum capacity
247.13 of eight residents, and which meet the requirements of Minnesota Rules, part 9555.6205,
247.14 subparts 1, 2, 3, and 4, item A.

247.15 Sec. 47. Minnesota Statutes 2008, section 256B.0915, subdivision 5, is amended to
247.16 read:
247.17 Subd. 5. **Assessments and reassessments for waiver clients.** (a) Each client
247.18 shall receive an initial assessment of strengths, informal supports, and need for services
247.19 in accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a
247.20 client served under the elderly waiver must be conducted at least every 12 months and at
247.21 other times when the case manager determines that there has been significant change in
247.22 the client's functioning. This may include instances where the client is discharged from
247.23 the hospital. There must be a determination that the client requires nursing facility level of
247.24 care as defined in section 144.0724, subdivision 11, at initial and subsequent assessments
247.25 to initiate and maintain participation in the waiver program.
247.26 (b) Regardless of other assessments identified in section 144.0724, subdivision
247.27 4, as appropriate to determine nursing facility level of care for purposes of medical
247.28 assistance payment for nursing facility services, only face-to-face assessments conducted
247.29 according to section 256B.0911, subdivisions 3a and 3b, that result in a nursing facility
247.30 level of care determination will be accepted for purposes of initial and ongoing access to
247.31 waiver service payment.

247.32 **EFFECTIVE DATE.** The section is effective July 1, 2011.

247.33 Sec. 48. Minnesota Statutes 2008, section 256B.0915, is amended by adding a
247.34 subdivision to read:

Subd. 10. **Waiver payment rates; managed care organizations.** The commissioner shall adjust the elderly waiver capitation payment rates for managed care organizations paid under section 256B.69, subdivisions 6a and 23, to reflect the maximum service rate limits for customized living services and 24-hour customized living services under subdivisions 3e and 3h for the contract period beginning October 1, 2009. Medical assistance rates paid to customized living providers by managed care organizations under this section shall not exceed the maximum service rate limits determined by the commissioner under subdivisions 3e and 3h.

Sec. 49. Minnesota Statutes 2008, section 256B.0916, subdivision 2, is amended to read:

Subd. 2. **Distribution of funds; partnerships.** (a) Beginning with fiscal year 2000, the commissioner shall distribute all funding available for home and community-based waiver services for persons with developmental disabilities to individual counties or to groups of counties that form partnerships to jointly plan, administer, and authorize funding for eligible individuals. The commissioner shall encourage counties to form partnerships that have a sufficient number of recipients and funding to adequately manage the risk and maximize use of available resources.

(b) Counties must submit a request for funds and a plan for administering the program as required by the commissioner. The plan must identify the number of clients to be served, their ages, and their priority listing based on:

(1) requirements in Minnesota Rules, part 9525.1880; and

(2) ~~unstable living situations due to the age or incapacity of the primary caregiver;~~ statewide priorities identified in section 256B.092, subdivision 12.

~~(3) the need for services to avoid out-of-home placement of children;~~

~~(4) the need to serve persons affected by private sector ICF/MR closures; and~~

~~(5) the need to serve persons whose consumer support grant exception amount was eliminated in 2004.~~

The plan must also identify changes made to improve services to eligible persons and to improve program management.

(c) In allocating resources to counties, priority must be given to groups of counties that form partnerships to jointly plan, administer, and authorize funding for eligible individuals and to counties determined by the commissioner to have sufficient waiver capacity to maximize resource use.

249.1 (d) Within 30 days after receiving the county request for funds and plans, the
249.2 commissioner shall provide a written response to the plan that includes the level of
249.3 resources available to serve additional persons.
249.4 (e) Counties are eligible to receive medical assistance administrative reimbursement
249.5 for administrative costs under criteria established by the commissioner.

249.6 Sec. 50. Minnesota Statutes 2008, section 256B.0917, is amended by adding a
249.7 subdivision to read:
249.8 Subd. 14. **Essential community supports grants.** (a) The purpose of the essential
249.9 community supports grant program is to provide targeted services to persons 65 years and
249.10 older who need essential community support, but whose needs do not meet the level of
249.11 care required for nursing facility placement under section 144.0724, subdivision 11.
249.12 (b) Within the limits of the appropriation and not to exceed $400 per person per
249.13 month, funding must be available to a person who:
249.14 (1) is age 65 or older;
249.15 (2) is not eligible for medical assistance;
249.16 (3) would otherwise be financially eligible for the alternative care program under
249.17 section 256B.0913, subdivision 4;
249.18 (4) has received a community assessment under section 256B.0911, subdivision 3a
249.19 or 3b, and does not require the level of care provided in a nursing facility;
249.20 (5) has a community support plan; and
249.21 (6) has been determined by a community assessment under section 256B.0911,
249.22 subdivision 3a or 3b, to be a person who would require provision of at least one of the
249.23 following services, as defined in the approved elderly waiver plan, in order to maintain
249.24 their community residence:
249.25 (i) caregiver support;
249.26 (ii) homemaker;
249.27 (iii) chore; or
249.28 (iv) a personal emergency response device or system.
249.29 (c) The person receiving any of the essential community supports in this subdivision
249.30 must also receive service coordination as part of their community support plan.
249.31 (d) A person who has been determined to be eligible for an essential community
249.32 support grant must be reassessed at least annually and continue to meet the criteria in
249.33 paragraph (b) to remain eligible for an essential community support grant.

(e) The commissioner shall allocate grants to counties and tribes under contract with the department based upon the historic use of the medical assistance elderly waiver and alternative care grant programs and other criteria as determined by the commissioner.

EFFECTIVE DATE. This section is effective July 1, 2011.

Sec. 51. Minnesota Statutes 2008, section 256B.092, subdivision 8a, is amended to read:

Subd. 8a. **County concurrence.** (a) If the county of financial responsibility wishes to place a person in another county for services, the county of financial responsibility shall seek concurrence from the proposed county of service and the placement shall be made cooperatively between the two counties. Arrangements shall be made between the two counties for ongoing social service, including annual reviews of the person's individual service plan. The county where services are provided may not make changes in the person's service plan without approval by the county of financial responsibility.

(b) When a person has been screened and authorized for services in an intermediate care facility for persons with developmental disabilities or for home and community-based services for persons with developmental disabilities, the case manager shall assist that person in identifying a service provider who is able to meet the needs of the person according to the person's individual service plan. If the identified service is to be provided in a county other than the county of financial responsibility, the county of financial responsibility shall request concurrence of the county where the person is requesting to receive the identified services. The county of service may refuse to concur if:

(1) it can demonstrate that the provider is unable to provide the services identified in the person's individual service plan as services that are needed and are to be provided; or

(2) in the case of an intermediate care facility for persons with developmental disabilities, there has been no authorization for admission by the admission review team as required in section 256B.0926~~; or~~.

~~(3) in the case of home and community-based services for persons with developmental disabilities, the county of service can demonstrate that the prospective provider has failed to substantially comply with the terms of a past contract or has had a prior contract terminated within the last 12 months for failure to provide adequate services, or has received a notice of intent to terminate the contract.~~

(c) The county of service shall notify the county of financial responsibility of concurrence or refusal to concur no later than 20 working days following receipt of the written request. Unless other mutually acceptable arrangements are made by the involved county agencies, the county of financial responsibility is responsible for costs of social

251.1 services and the costs associated with the development and maintenance of the placement.
251.2 The county of service may request that the county of financial responsibility purchase
251.3 case management services from the county of service or from a contracted provider
251.4 of case management when the county of financial responsibility is not providing case
251.5 management as defined in this section and rules adopted under this section, unless other
251.6 mutually acceptable arrangements are made by the involved county agencies. Standards
251.7 for payment limits under this section may be established by the commissioner. Financial
251.8 disputes between counties shall be resolved as provided in section 256G.09.

251.9 Sec. 52. Minnesota Statutes 2008, section 256B.092, is amended by adding a
251.10 subdivision to read:
251.11 Subd. 11. **Residential support services.** (a) Upon federal approval, there is
251.12 established a new service called residential support that is available on the CAC, CADI,
251.13 DD, and TBI waivers. Existing waiver service descriptions must be modified to the extent
251.14 necessary to ensure there is no duplication between other services. Residential support
251.15 services must be provided by vendors licensed under category community residential
251.16 setting as defined in section 245A.11, subdivision 8.
251.17 (b) Residential support services must meet the following criteria:
251.18 (1) providers of residential support services must own or control the residential site;
251.19 (2) the residential site must not be the primary residence of the license holder;
251.20 (3) the residential site must have a designated program supervisor responsible for
251.21 program oversight, development, and implementation of policies and procedures;
251.22 (4) the provider of residential support services must provide supervision, training,
251.23 and assistance as described in the person's community support plan; and
251.24 (5) the provider of residential support services must meet the requirements of
251.25 licensure and additional requirements of the person's community support plan.
251.26 (c) Providers of residential support services that meet the definition in paragraph (a)
251.27 must be registered using a process determined by the commissioner beginning July 1, 2009.

251.28 Sec. 53. Minnesota Statutes 2008, section 256B.092, is amended by adding a
251.29 subdivision to read:
251.30 Subd. 12. **Waivered services statewide priorities.** (a) The commissioner shall
251.31 establish statewide priorities for individuals on the waiting list for developmental
251.32 disabilities (DD) waiver services, as of January 1, 2010. The statewide priorities must
251.33 include, but are not limited to, individuals who continue to have a need for waiver services
251.34 after they have maximized the use of state plan services and other funding resources,

252.1 including natural supports, prior to accessing waiver services, and who meet at least one
252.2 of the following criteria:
252.3 (1) have unstable living situations due to the age, incapacity, or sudden loss of
252.4 the primary caregivers;
252.5 (2) are moving from an institution due to bed closures;
252.6 (3) experience a sudden closure of their current living arrangement;
252.7 (4) require protection from confirmed abuse, neglect, or exploitation;
252.8 (5) experience a sudden change in need that can no longer be met through state plan
252.9 services or other funding resources alone; or
252.10 (6) meet other priorities established by the department.
252.11 (b) When allocating resources to lead agencies, the commissioner shall take into
252.12 consideration the number of individuals waiting who meet statewide priorities.
252.13 (c) The commissioner shall evaluate the impact of the use of statewide priorities and
252.14 provide recommendations to the legislature on whether to continue the use of statewide
252.15 priorities in the November 1, 2011, annual report required by the commissioner in sections
252.16 256B.0916, subdivision 7, and 256B.49, subdivision 21.

252.17 Sec. 54. Minnesota Statutes 2008, section 256B.37, subdivision 1, is amended to read:
252.18 Subdivision 1. **Subrogation.** Upon furnishing medical assistance or alternative
252.19 care services under section 256B.0913 to any person who has private accident or health
252.20 care coverage, or receives or has a right to receive health or medical care from any
252.21 type of organization or entity, or has a cause of action arising out of an occurrence that
252.22 necessitated the payment of medical assistance, the state agency or the state agency's agent
252.23 shall be subrogated, to the extent of the cost of medical care furnished, to any rights the
252.24 person may have under the terms of the coverage, or against the organization or entity
252.25 providing or liable to provide health or medical care, or under the cause of action.
252.26 The right of subrogation created in this section includes all portions of the cause
252.27 of action, notwithstanding any settlement allocation or apportionment that purports to
252.28 dispose of portions of the cause of action not subject to subrogation.

252.29 Sec. 55. Minnesota Statutes 2008, section 256B.37, subdivision 5, is amended to read:
252.30 Subd. 5. **Private benefits to be used first.** Private accident and health care coverage
252.31 including Medicare for medical services is primary coverage and must be exhausted before
252.32 medical assistance ~~is~~ or alternative care services are paid for medical services including
252.33 home health care, personal care assistant services, hospice, supplies and equipment, or
252.34 services covered under a Centers for Medicare and Medicaid Services waiver. When a

253.1 person who is otherwise eligible for medical assistance has private accident or health care
253.2 coverage, including Medicare or a prepaid health plan, the private health care benefits
253.3 available to the person must be used first and to the fullest extent.

253.4 Sec. 56. Minnesota Statutes 2008, section 256B.437, subdivision 6, is amended to read:
253.5 Subd. 6. **Planned closure rate adjustment.** (a) The commissioner of human
253.6 services shall calculate the amount of the planned closure rate adjustment available under
253.7 subdivision 3, paragraph (b), for up to 5,140 beds according to clauses (1) to (4):
253.8 (1) the amount available is the net reduction of nursing facility beds multiplied
253.9 by $2,080;
253.10 (2) the total number of beds in the nursing facility or facilities receiving the planned
253.11 closure rate adjustment must be identified;
253.12 (3) capacity days are determined by multiplying the number determined under
253.13 clause (2) by 365; and
253.14 (4) the planned closure rate adjustment is the amount available in clause (1), divided
253.15 by capacity days determined under clause (3).
253.16 (b) A planned closure rate adjustment under this section is effective on the first day
253.17 of the month following completion of closure of the facility designated for closure in the
253.18 application and becomes part of the nursing facility's total operating payment rate.
253.19 (c) Applicants may use the planned closure rate adjustment to allow for a property
253.20 payment for a new nursing facility or an addition to an existing nursing facility or as an
253.21 operating payment rate adjustment. Applications approved under this subdivision are
253.22 exempt from other requirements for moratorium exceptions under section 144A.073,
253.23 subdivisions 2 and 3.
253.24 (d) Upon the request of a closing facility, the commissioner must allow the facility a
253.25 closure rate adjustment as provided under section 144A.161, subdivision 10.
253.26 (e) A facility that has received a planned closure rate adjustment may reassign it
253.27 to another facility that is under the same ownership at any time within three years of its
253.28 effective date. The amount of the adjustment shall be computed according to paragraph (a).
253.29 (f) If the per bed dollar amount specified in paragraph (a), clause (1), is increased,
253.30 the commissioner shall recalculate planned closure rate adjustments for facilities that
253.31 delicense beds under this section on or after July 1, 2001, to reflect the increase in the per
253.32 bed dollar amount. The recalculated planned closure rate adjustment shall be effective
253.33 from the date the per bed dollar amount is increased.

254.1 (g) For planned closures approved after June 30, 2009, the commissioner of human
254.2 services shall calculate the amount of the planned closure rate adjustment available under
254.3 subdivision 3, paragraph (b), according to paragraph (a), clauses (1) to (4).

254.4 Sec. 57. Minnesota Statutes 2008, section 256B.441, is amended by adding a
254.5 subdivision to read:

254.6 Subd. 24a. **Medicare costs.** For purposes of computing rates under this section for
254.7 rate years beginning on or after October 1, 2009, "Medicare costs" means 70.4 percent of
254.8 Medicare Part A and Part B revenues received during the reporting year.

254.9 Sec. 58. Minnesota Statutes 2008, section 256B.441, subdivision 48, is amended to
254.10 read:

254.11 Subd. 48. **Calculation of operating per diems.** The direct care per diem for
254.12 each facility shall be the facility's direct care costs divided by its standardized days.
254.13 The other care-related per diem shall be the sum of the facility's activities costs, other
254.14 direct care costs, raw food costs, therapy costs, and social services costs, divided by the
254.15 facility's resident days. The other operating per diem shall be the sum of the facility's
254.16 administrative costs, dietary costs, housekeeping costs, laundry costs, and maintenance
254.17 and plant operations costs divided by the facility's resident days. For rate years beginning
254.18 on or after October 1, 2009, the calculations of the direct care per diem, other care-related
254.19 per diem, and other operating per diem shall:

254.20 (1) have allowable costs reduced by Medicare costs as defined in subdivision 24a.
254.21 The Medicare costs must be allocated between direct care, other care-related, and other
254.22 operating based on a ratio of allowable expenses from the cost report; and

254.23 (2) have resident days and standardized days computed without using days paid
254.24 by Medicare.

254.25 Sec. 59. Minnesota Statutes 2008, section 256B.441, subdivision 55, is amended to
254.26 read:

254.27 Subd. 55. **Phase-in of rebased operating payment rates.** (a) For the rate years
254.28 beginning October 1, 2008, to October 1, 2015, the operating payment rate calculated
254.29 under this section shall be phased in by blending the operating rate with the operating
254.30 payment rate determined under section 256B.434. For purposes of this subdivision, the
254.31 rate to be used that is determined under section 256B.434 shall not include the portion of
254.32 the operating payment rate related to performance-based incentive payments under section
254.33 256B.434, subdivision 4, paragraph (d). For the rate year beginning October 1, 2008, the

255.1 operating payment rate for each facility shall be 13 percent of the operating payment rate
255.2 from this section, and 87 percent of the operating payment rate from section 256B.434.
255.3 For the rate ~~year~~ period beginning October 1, 2009, through September 30, 2013, the
255.4 operating payment rate for each facility shall be 14 percent of the operating payment rate
255.5 from this section, and 86 percent of the operating payment rate from section 256B.434.
255.6 ~~For the rate year beginning October 1, 2010, the operating payment rate for each facility~~
255.7 ~~shall be 14 percent of the operating payment rate from this section, and 86 percent of the~~
255.8 ~~operating payment rate from section 256B.434. For the rate year beginning October 1,~~
255.9 ~~2011, the operating payment rate for each facility shall be 31 percent of the operating~~
255.10 ~~payment rate from this section, and 69 percent of the operating payment rate from section~~
255.11 ~~256B.434. For the rate year beginning October 1, 2012, the operating payment rate for~~
255.12 ~~each facility shall be 48 percent of the operating payment rate from this section, and 52~~
255.13 ~~percent of the operating payment rate from section 256B.434.~~ For the rate year beginning
255.14 October 1, 2013, the operating payment rate for each facility shall be 65 percent of the
255.15 operating payment rate from this section, and 35 percent of the operating payment rate
255.16 from section 256B.434. For the rate year beginning October 1, 2014, the operating
255.17 payment rate for each facility shall be 82 percent of the operating payment rate from this
255.18 section, and 18 percent of the operating payment rate from section 256B.434. For the rate
255.19 year beginning October 1, 2015, the operating payment rate for each facility shall be the
255.20 operating payment rate determined under this section. The blending of operating payment
255.21 rates under this section shall be performed separately for each RUG's class.

255.22 (b) For the rate year beginning October 1, 2008, the commissioner shall apply limits
255.23 to the operating payment rate increases under paragraph (a) by creating a minimum
255.24 percentage increase and a maximum percentage increase.

255.25 (1) Each nursing facility that receives a blended October 1, 2008, operating payment
255.26 rate increase under paragraph (a) of less than one percent, when compared to its operating
255.27 payment rate on September 30, 2008, computed using rates with RUG's weight of 1.00,
255.28 shall receive a rate adjustment of one percent.

255.29 (2) The commissioner shall determine a maximum percentage increase that will
255.30 result in savings equal to the cost of allowing the minimum increase in clause (1). Nursing
255.31 facilities with a blended October 1, 2008, operating payment rate increase under paragraph
255.32 (a) greater than the maximum percentage increase determined by the commissioner, when
255.33 compared to its operating payment rate on September 30, 2008, computed using rates with
255.34 a RUG's weight of 1.00, shall receive the maximum percentage increase.

255.35 (3) Nursing facilities with a blended October 1, 2008, operating payment rate
255.36 increase under paragraph (a) greater than one percent and less than the maximum

256.1 percentage increase determined by the commissioner, when compared to its operating
256.2 payment rate on September 30, 2008, computed using rates with a RUG's weight of 1.00,
256.3 shall receive the blended October 1, 2008, operating payment rate increase determined
256.4 under paragraph (a).

256.5 (4) The October 1, 2009, through October 1, 2015, operating payment rate for
256.6 facilities receiving the maximum percentage increase determined in clause (2) shall be
256.7 the amount determined under paragraph (a) less the difference between the amount
256.8 determined under paragraph (a) for October 1, 2008, and the amount allowed under clause
256.9 (2). This rate restriction does not apply to rate increases provided in any other section.

256.10 (c) A portion of the funds received under this subdivision that are in excess of
256.11 operating payment rates that a facility would have received under section 256B.434, as
256.12 determined in accordance with clauses (1) to (3), shall be subject to the requirements in
256.13 section 256B.434, subdivision 19, paragraphs (b) to (h).

256.14 (1) Determine the amount of additional funding available to a facility, which shall be
256.15 equal to total medical assistance resident days from the most recent reporting year times
256.16 the difference between the blended rate determined in paragraph (a) for the rate year being
256.17 computed and the blended rate for the prior year.

256.18 (2) Determine the portion of all operating costs, for the most recent reporting year,
256.19 that are compensation related. If this value exceeds 75 percent, use 75 percent.

256.20 (3) Subtract the amount determined in clause (2) from 75 percent.

256.21 (4) The portion of the fund received under this subdivision that shall be subject to
256.22 the requirements in section 256B.434, subdivision 19, paragraphs (b) to (h), shall equal
256.23 the amount determined in clause (1) times the amount determined in clause (3).

256.24 Sec. 60. Minnesota Statutes 2008, section 256B.441, is amended by adding a
256.25 subdivision to read:

256.26 Subd. 59. **Single-bed payments for medical assistance recipients.** Effective
256.27 October 1, 2009, the amount paid for a private room under Minnesota Rules, part
256.28 9549.0070, subpart 3, is reduced from 115 percent to 111.5 percent.

256.29 Sec. 61. Minnesota Statutes 2008, section 256B.49, is amended by adding a
256.30 subdivision to read:

256.31 Subd. 11a. **Waivered services waiting list.** (a) The commissioner shall establish
256.32 statewide priorities for individuals on the waiting list for CAC, CADI, and TBI waiver
256.33 services, as of January 1, 2010. The statewide priorities must include, but are not limited
256.34 to, individuals who continue to have a need for waiver services after they have maximized

257.1 the use of state plan services and other funding resources, including natural supports, prior
257.2 to accessing waiver services, and who meet at least one of the following criteria:
257.3 (1) have unstable living situations due to the age, incapacity, or sudden loss of
257.4 the primary caregivers;
257.5 (2) are moving from an institution due to bed closures;
257.6 (3) experience a sudden closure of their current living arrangement;
257.7 (4) require protection from confirmed abuse, neglect, or exploitation;
257.8 (5) experience a sudden change in need that can no longer be met through state plan
257.9 services or other funding resources alone; or
257.10 (6) meet other priorities established by the department.
257.11 (b) When allocating resources to lead agencies, the commissioner shall take into
257.12 consideration the number of individuals waiting who meet statewide priorities.
257.13 (c) The commissioner shall evaluate the impact of the use of statewide priorities and
257.14 provide recommendations to the legislature on whether to continue the use of statewide
257.15 priorities in the November 1, 2011, annual report required by the commissioner in sections
257.16 256B.0916, subdivision 7, and 256B.49, subdivision 21.

257.17 Sec. 62. Minnesota Statutes 2008, section 256B.49, subdivision 12, is amended to read:
257.18 Subd. 12. **Informed choice.** Persons who are determined likely to require the
257.19 level of care provided in a nursing facility as determined under sections 256B.0911 and
257.20 144.0724, subdivision 11, or hospital shall be informed of the home and community-based
257.21 support alternatives to the provision of inpatient hospital services or nursing facility
257.22 services. Each person must be given the choice of either institutional or home and
257.23 community-based services using the provisions described in section 256B.77, subdivision
257.24 2, paragraph (p).

257.25 **EFFECTIVE DATE.** The section is effective July 1, 2011.

257.26 Sec. 63. Minnesota Statutes 2008, section 256B.49, subdivision 13, is amended to read:
257.27 Subd. 13. **Case management.** (a) Each recipient of a home and community-based
257.28 waiver shall be provided case management services by qualified vendors as described
257.29 in the federally approved waiver application. The case management service activities
257.30 provided will include:
257.31 (1) assessing the needs of the individual within 20 working days of a recipient's
257.32 request;
257.33 (2) developing the written individual service plan within ten working days after the
257.34 assessment is completed;

258.1 (3) informing the recipient or the recipient's legal guardian or conservator of service
258.2 options;
258.3 (4) assisting the recipient in the identification of potential service providers;
258.4 (5) assisting the recipient to access services;
258.5 (6) coordinating, evaluating, and monitoring of the services identified in the service
258.6 plan;
258.7 (7) completing the annual reviews of the service plan; and
258.8 (8) informing the recipient or legal representative of the right to have assessments
258.9 completed and service plans developed within specified time periods, and to appeal county
258.10 action or inaction under section 256.045, subdivision 3, including the determination of
258.11 nursing facility level of care.
258.12 (b) The case manager may delegate certain aspects of the case management service
258.13 activities to another individual provided there is oversight by the case manager. The case
258.14 manager may not delegate those aspects which require professional judgment including
258.15 assessments, reassessments, and care plan development.

258.16 Sec. 64. Minnesota Statutes 2008, section 256B.49, subdivision 14, is amended to read:
258.17 Subd. 14. **Assessment and reassessment.** (a) Assessments of each recipient's
258.18 strengths, informal support systems, and need for services shall be completed within
258.19 20 working days of the recipient's request. Reassessment of each recipient's strengths,
258.20 support systems, and need for services shall be conducted at least every 12 months and at
258.21 other times when there has been a significant change in the recipient's functioning.
258.22 (b) There must be a determination that the client requires a hospital level of care or a
258.23 nursing facility level of care as defined in section 144.0724, subdivision 11, at initial and
258.24 subsequent assessments to initiate and maintain participation in the waiver program.
258.25 (c) Regardless of other assessments identified in section 144.0724, subdivision 4, as
258.26 appropriate to determine nursing facility level of care for purposes of medical assistance
258.27 payment for nursing facility services, only face-to-face assessments conducted according
258.28 to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care
258.29 determination or a nursing facility level of care determination must be accepted for
258.30 purposes of initial and ongoing access to waiver services payment.
258.31 (d) Persons with developmental disabilities who apply for services under the nursing
258.32 facility level waiver programs shall be screened for the appropriate level of care according
258.33 to section 256B.092.

259.1 ~~(c)~~ (e) Recipients who are found eligible for home and community-based services
259.2 under this section before their 65th birthday may remain eligible for these services after
259.3 their 65th birthday if they continue to meet all other eligibility factors.

259.4 **EFFECTIVE DATE.** The section is effective July 1, 2011.

259.5 Sec. 65. Minnesota Statutes 2008, section 256B.49, is amended by adding a
259.6 subdivision to read:

259.7 Subd. 22. **Residential support services.** For the purposes of this section, the
259.8 provisions of section 256B.092, subdivision 11, are controlling.

259.9 Sec. 66. **[256B.4912] HOME AND COMMUNITY-BASED WAIVERS;**
259.10 **PROVIDERS AND PAYMENT.**

259.11 Subdivision 1. **Provider qualifications.** For the home and community-based
259.12 waivers providing services to seniors and individuals with disabilities, the commissioner
259.13 shall establish:

259.14 (1) agreements with enrolled waiver service providers to ensure providers meet
259.15 qualifications defined in the waiver plans;

259.16 (2) regular reviews of provider qualifications; and

259.17 (3) processes to gather the necessary information to determine provider
259.18 qualifications.

259.19 By July 2010, staff that provide direct contact, as defined in section 245C.02, subdivision
259.20 11, that are employees of waiver service providers must meet the requirements of chapter
259.21 245C prior to providing waiver services and as part of ongoing enrollment. Upon federal
259.22 approval, this requirement must also apply to consumer-directed community supports.

259.23 Subd. 2. **Rate-setting methodologies.** The commissioner shall establish
259.24 statewide rate-setting methodologies that meet federal waiver requirements for home
259.25 and community-based waiver services for individuals with disabilities. The rate-setting
259.26 methodologies must utilize person-centered methods that result in quality of life beyond
259.27 custodial care, promote individual choice and service stability, are understandable to
259.28 families and nonfinancial county staff, are equitable across the state, are transparent and
259.29 available to the public, and are flexible to adapt to recipients' individual service needs.
259.30 The methodologies must involve a uniform process of structuring rates for each service
259.31 and must promote quality and participant choice.

Sec. 67. Minnesota Statutes 2008, section 256B.5011, subdivision 2, is amended to read:

Subd. 2. **Contract provisions.** (a) The service contract with each intermediate care facility must include provisions for:

(1) modifying payments when significant changes occur in the needs of the consumers;

(2) ~~the establishment and use of a quality improvement plan. Using criteria and options for performance measures developed by the commissioner, each intermediate care facility must identify a minimum of one performance measure on which to focus its efforts for quality improvement during the contract period;~~

~~(3)~~ appropriate and necessary statistical information required by the commissioner;

~~(4)~~ annual aggregate facility financial information; and

~~(5)~~ (4) additional requirements for intermediate care facilities not meeting the standards set forth in the service contract.

(b) The commissioner of human services and the commissioner of health, in consultation with representatives from counties, advocacy organizations, and the provider community, shall review the consolidated standards under chapter 245B and the supervised living facility rule under Minnesota Rules, chapter 4665, to determine what provisions in Minnesota Rules, chapter 4665, may be waived by the commissioner of health for intermediate care facilities in order to enable facilities to implement the performance measures in their contract and provide quality services to residents without a duplication of or increase in regulatory requirements.

Sec. 68. Minnesota Statutes 2008, section 256B.5012, is amended by adding a subdivision to read:

Subd. 8. **ICF/MR rate decreases effective July 1, 2009.** The commissioner shall decrease each facility reimbursed under this section operating payment adjustments equal to 3.0 percent of the operating payment rates in effect on June 30, 2009. For each facility, the commissioner shall implement the rate reduction, based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding date. The total rate reduction shall include the adjustment provided in section 256B.502, subdivision 7.

Sec. 69. Minnesota Statutes 2008, section 256B.5013, subdivision 1, is amended to read:

261.1 Subdivision 1. **Variable rate adjustments.** (a) For rate years beginning on or after
261.2 October 1, 2000, when there is a documented increase in the needs of a current ICF/MR
261.3 recipient, the county of financial responsibility may recommend a variable rate to enable
261.4 the facility to meet the individual's increased needs. Variable rate adjustments made under
261.5 this subdivision replace payments for persons with special needs under section 256B.501,
261.6 subdivision 8, and payments for persons with special needs for crisis intervention services
261.7 under section 256B.501, subdivision 8a. Effective July 1, 2003, facilities with a base rate
261.8 above the 50th percentile of the statewide average reimbursement rate for a Class A
261.9 facility or Class B facility, whichever matches the facility licensure, are not eligible for a
261.10 variable rate adjustment. Variable rate adjustments may not exceed a 12-month period,
261.11 except when approved for purposes established in paragraph (b), clause (1). Variable rate
261.12 adjustments approved solely on the basis of changes on a developmental disabilities
261.13 screening document will end June 30, 2002.

261.14 (b) A variable rate may be recommended by the county of financial responsibility
261.15 for increased needs in the following situations:

261.16 (1) a need for resources due to an individual's full or partial retirement from
261.17 participation in a day training and habilitation service when the individual: (i) has reached
261.18 the age of 65 or has a change in health condition that makes it difficult for the person
261.19 to participate in day training and habilitation services over an extended period of time
261.20 because it is medically contraindicated; and (ii) has expressed a desire for change through
261.21 the developmental disability screening process under section 256B.092;

261.22 (2) a need for additional resources for intensive short-term programming which is
261.23 necessary prior to an individual's discharge to a less restrictive, more integrated setting;

261.24 (3) a demonstrated medical need that significantly impacts the type or amount of
261.25 services needed by the individual; or

261.26 (4) a demonstrated behavioral need that significantly impacts the type or amount of
261.27 services needed by the individual.

261.28 (c) The county of financial responsibility must justify the purpose, the projected
261.29 length of time, and the additional funding needed for the facility to meet the needs of
261.30 the individual.

261.31 (d) ~~The facility shall provide a quarterly report to the county case manager on~~
261.32 ~~the use of the variable rate funds and the status of the individual on whose behalf the~~
261.33 ~~funds were approved. The county case manager will forward the facility's report with a~~
261.34 ~~recommendation to the commissioner to approve or disapprove a continuation of the~~
261.35 ~~variable rate.~~

262.1 ~~(c)~~ Funds made available through the variable rate process that are not used by
262.2 the facility to meet the needs of the individual for whom they were approved shall be
262.3 returned to the state.

262.4 Sec. 70. Minnesota Statutes 2008, section 256B.69, subdivision 5a, is amended to read:
262.5 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section
262.6 and sections 256L.12 and 256D.03, shall be entered into or renewed on a calendar year
262.7 basis beginning January 1, 1996. Managed care contracts which were in effect on June
262.8 30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995
262.9 through December 31, 1995 at the same terms that were in effect on June 30, 1995. The
262.10 commissioner may issue separate contracts with requirements specific to services to
262.11 medical assistance recipients age 65 and older.
262.12 (b) A prepaid health plan providing covered health services for eligible persons
262.13 pursuant to chapters 256B, 256D, and 256L, is responsible for complying with the terms
262.14 of its contract with the commissioner. Requirements applicable to managed care programs
262.15 under chapters 256B, 256D, and 256L, established after the effective date of a contract
262.16 with the commissioner take effect when the contract is next issued or renewed.
262.17 (c) Effective for services rendered on or after January 1, 2003, the commissioner
262.18 shall withhold five percent of managed care plan payments under this section for the
262.19 prepaid medical assistance and general assistance medical care programs pending
262.20 completion of performance targets. Each performance target must be quantifiable,
262.21 objective, measurable, and reasonably attainable, except in the case of a performance
262.22 target based on a federal or state law or rule. Criteria for assessment of each performance
262.23 target must be outlined in writing prior to the contract effective date. The managed
262.24 care plan must demonstrate, to the commissioner's satisfaction, that the data submitted
262.25 regarding attainment of the performance target is accurate. The commissioner shall
262.26 periodically change the administrative measures used as performance targets in order
262.27 to improve plan performance across a broader range of administrative services. The
262.28 performance targets must include measurement of plan efforts to contain spending
262.29 on health care services and administrative activities. The commissioner may adopt
262.30 plan-specific performance targets that take into account factors affecting only one plan,
262.31 including characteristics of the plan's enrollee population. The withheld funds must be
262.32 returned no sooner than July of the following year if performance targets in the contract
262.33 are achieved. The commissioner may exclude special demonstration projects under
262.34 subdivision 23. A managed care plan or a county-based purchasing plan under section

263.1 256B.692 may include as admitted assets under section 62D.044 any amount withheld
263.2 under this paragraph that is reasonably expected to be returned.
263.3 (d)(1) Effective for services rendered on or after January 1, 2009, the commissioner
263.4 shall withhold three percent of managed care plan payments under this section for the
263.5 prepaid medical assistance and general assistance medical care programs. The withheld
263.6 funds must be returned no sooner than July 1 and no later than July 31 of the following
263.7 year. The commissioner may exclude special demonstration projects under subdivision 23.
263.8 (2) A managed care plan or a county-based purchasing plan under section 256B.692
263.9 may include as admitted assets under section 62D.044 any amount withheld under
263.10 this paragraph. The return of the withhold under this paragraph is not subject to the
263.11 requirements of paragraph (c).
263.12 (e) Effective for services provided on or after January 1, 2010, the commissioner
263.13 shall require that managed care plans use the fee-for-service medical assistance assessment
263.14 and authorization processes, forms, timelines, standards, documentation, and data
263.15 reporting requirements, protocols, billing processes, and policies for all personal care
263.16 assistance services under section 256B.0659.

263.17 Sec. 71. Minnesota Statutes 2008, section 256D.44, subdivision 5, is amended to read:
263.18 Subd. 5. **Special needs.** In addition to the state standards of assistance established in
263.19 subdivisions 1 to 4, payments are allowed for the following special needs of recipients of
263.20 Minnesota supplemental aid who are not residents of a nursing home, a regional treatment
263.21 center, or a group residential housing facility.
263.22 (a) The county agency shall pay a monthly allowance for medically prescribed
263.23 diets if the cost of those additional dietary needs cannot be met through some other
263.24 maintenance benefit. The need for special diets or dietary items must be prescribed by
263.25 a licensed physician. Costs for special diets shall be determined as percentages of the
263.26 allotment for a one-person household under the thrifty food plan as defined by the United
263.27 States Department of Agriculture. The types of diets and the percentages of the thrifty
263.28 food plan that are covered are as follows:
263.29 (1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;
263.30 (2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent
263.31 of thrifty food plan;
263.32 (3) controlled protein diet, less than 40 grams and requires special products, 125
263.33 percent of thrifty food plan;
263.34 (4) low cholesterol diet, 25 percent of thrifty food plan;
263.35 (5) high residue diet, 20 percent of thrifty food plan;

264.1 (6) pregnancy and lactation diet, 35 percent of thrifty food plan;
264.2 (7) gluten-free diet, 25 percent of thrifty food plan;
264.3 (8) lactose-free diet, 25 percent of thrifty food plan;
264.4 (9) antidumping diet, 15 percent of thrifty food plan;
264.5 (10) hypoglycemic diet, 15 percent of thrifty food plan; or
264.6 (11) ketogenic diet, 25 percent of thrifty food plan.
264.7 (b) Payment for nonrecurring special needs must be allowed for necessary home
264.8 repairs or necessary repairs or replacement of household furniture and appliances using
264.9 the payment standard of the AFDC program in effect on July 16, 1996, for these expenses,
264.10 as long as other funding sources are not available.
264.11 (c) A fee for guardian or conservator service is allowed at a reasonable rate
264.12 negotiated by the county or approved by the court. This rate shall not exceed five percent
264.13 of the assistance unit's gross monthly income up to a maximum of $100 per month. If the
264.14 guardian or conservator is a member of the county agency staff, no fee is allowed.
264.15 (d) The county agency shall continue to pay a monthly allowance of $68 for
264.16 restaurant meals for a person who was receiving a restaurant meal allowance on June 1,
264.17 1990, and who eats two or more meals in a restaurant daily. The allowance must continue
264.18 until the person has not received Minnesota supplemental aid for one full calendar month
264.19 or until the person's living arrangement changes and the person no longer meets the criteria
264.20 for the restaurant meal allowance, whichever occurs first.
264.21 (e) A fee of ten percent of the recipient's gross income or $25, whichever is less,
264.22 is allowed for representative payee services provided by an agency that meets the
264.23 requirements under SSI regulations to charge a fee for representative payee services. This
264.24 special need is available to all recipients of Minnesota supplemental aid regardless of
264.25 their living arrangement.
264.26 (f)(1) Notwithstanding the language in this subdivision, an amount equal to the
264.27 maximum allotment authorized by the federal Food Stamp Program for a single individual
264.28 which is in effect on the first day of July of each year will be added to the standards of
264.29 assistance established in subdivisions 1 to 4 for adults under the age of 65 who qualify
264.30 as shelter needy and are: (i) relocating from an institution, or an adult mental health
264.31 residential treatment program under section 256B.0622; (ii) eligible for the self-directed
264.32 supports option as defined under section 256B.0657, subdivision 2; or (iii) home and
264.33 community-based waiver recipients living in their own home or rented or leased apartment
264.34 which is not owned, operated, or controlled by a provider of service not related by blood
264.35 or marriage.

265.1 (2) Notwithstanding subdivision 3, paragraph (c), an individual eligible for the
265.2 shelter needy benefit under this paragraph is considered a household of one. An eligible
265.3 individual who receives this benefit prior to age 65 may continue to receive the benefit
265.4 after the age of 65.

265.5 (3) "Shelter needy" means that the assistance unit incurs monthly shelter costs that
265.6 exceed 40 percent of the assistance unit's gross income before the application of this
265.7 special needs standard. "Gross income" for the purposes of this section is the applicant's or
265.8 recipient's income as defined in section 256D.35, subdivision 10, or the standard specified
265.9 in subdivision 3, paragraph (a) or (b), whichever is greater. A recipient of a federal or
265.10 state housing subsidy, that limits shelter costs to a percentage of gross income, shall not be
265.11 considered shelter needy for purposes of this paragraph.

265.12 (g) Notwithstanding this subdivision, recipients of home and community-based
265.13 services may relocate to services without 24-hour supervision and receive the equivalent
265.14 of the recipient's group residential housing allocation in Minnesota supplemental
265.15 assistance shelter needy funding if the cost of the services and housing is equal to or less
265.16 than provided to the recipient in home and community-based services and the relocation is
265.17 the recipient's choice and is approved by the recipient or guardian.

265.18 (h) To access housing and services as provided in paragraph (g), the recipient may
265.19 choose housing that may or may not be owned, operated, or controlled by the recipient's
265.20 service provider.

265.21 (i) The provisions in paragraphs (g) and (h) are effective to June 30, 2011. The
265.22 commissioner shall assess the development of publicly owned housing, other housing
265.23 alternatives, and whether a public equity housing fund may be established that would
265.24 maintain the state's interest, to the extent paid from group residential housing and
265.25 Minnesota supplemental aid shelter needy funds in provider-owned housing so that when
265.26 sold, the state would recover its share for a public equity fund to be used for future public
265.27 needs under this chapter. The commissioner shall report findings and recommendations to
265.28 the legislative committees and budget divisions with jurisdiction over health and human
265.29 services policy and financing by January 15, 2012.

265.30 (j) In selecting prospective services needed by recipients for whom home and
265.31 community-based services have been authorized, the recipient and the recipient's guardian
265.32 shall first consider alternatives to home and community-based services. Minnesota
265.33 supplemental aid shelter needy funding for recipients who utilize Minnesota supplemental
265.34 aid shelter needy funding as provided in this section shall remain permanent unless the
265.35 recipient with the recipient's guardian later chooses to access home and community-based
265.36 services.

266.1 Sec. 72. Minnesota Statutes 2008, section 626.556, subdivision 3c, is amended to read:
266.2 Subd. 3c. **Local welfare agency, Department of Human Services or Department**
266.3 **of Health responsible for assessing or investigating reports of maltreatment.** (a)
266.4 The county local welfare agency is the agency responsible for assessing or investigating
266.5 allegations of maltreatment in child foster care, family child care, ~~and~~ legally unlicensed
266.6 child care ~~and in~~, juvenile correctional facilities licensed under section 241.021 located
266.7 in the local welfare agency's county, and unlicensed personal care assistance provider
266.8 organizations providing services and receiving reimbursements under chapter 256B.
266.9 (b) The Department of Human Services is the agency responsible for assessing or
266.10 investigating allegations of maltreatment in facilities licensed under chapters 245A and
266.11 245B, except for child foster care and family child care.
266.12 (c) The Department of Health is the agency responsible for assessing or investigating
266.13 allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58 and
266.14 144A.46, and in unlicensed home health care.
266.15 (d) The commissioners of human services, public safety, and education must
266.16 jointly submit a written report by January 15, 2007, to the education policy and finance
266.17 committees of the legislature recommending the most efficient and effective allocation
266.18 of agency responsibility for assessing or investigating reports of maltreatment and must
266.19 specifically address allegations of maltreatment that currently are not the responsibility
266.20 of a designated agency.

266.21 Sec. 73. Minnesota Statutes 2008, section 626.5572, subdivision 13, is amended to
266.22 read:
266.23 Subd. 13. **Lead agency.** "Lead agency" is the primary administrative agency
266.24 responsible for investigating reports made under section 626.557.
266.25 (a) The Department of Health is the lead agency for the facilities which are licensed
266.26 or are required to be licensed as hospitals, home care providers, nursing homes, residential
266.27 care homes, or boarding care homes.
266.28 (b) The Department of Human Services is the lead agency for the programs licensed
266.29 or required to be licensed as adult day care, adult foster care, programs for people with
266.30 developmental disabilities, mental health programs, or chemical health programs~~, or~~
266.31 ~~personal care provider organizations~~.
266.32 (c) The county social service agency or its designee is the lead agency for all other
266.33 reports, including personal care provider organizations under section 256B.0659.

267.1 Sec. 74. **COMMISSIONER TO REPORT ON PERSONAL CARE ASSISTANCE**
267.2 **PROGRAM.**

267.3 The commissioner of human services must report to the legislative committees
267.4 with jurisdiction over health and human services policy and finance by January 1, 2010,
267.5 on the training developed and delivered for all types of participants in the personal
267.6 care assistance program, audit and financial integrity measures and results, information
267.7 developed for consumers and responsible parties, available demographic, health care
267.8 service use, and housing information about individuals who no longer qualify for personal
267.9 care assistance, and quality assurance measures and results.

267.10 Sec. 75. **COLA COMPENSATION REQUIREMENTS.**

267.11 Effective July 1, 2009, providers who received rate increases under Laws 2007,
267.12 chapter 147, article 7, section 71, as amended by Laws 2008, chapter 363, article 15,
267.13 section 17, and Minnesota Statutes, section 256B.5012, subdivision 7, for state fiscal years
267.14 2008 and 2009 are no longer required to continue or retain employee compensation or
267.15 wage-related increases required by those sections.

267.16 Sec. 76. **PROVIDER RATE AND GRANT REDUCTIONS.**

267.17 (a) The commissioner of human services shall decrease grants, allocations,
267.18 reimbursement rates, or rate limits, as applicable, by 3.0 percent effective July 1, 2009, for
267.19 services rendered on or after that date. County or tribal contracts for services specified
267.20 in this section must be amended to pass through these rate reductions within 60 days of
267.21 the effective date of the decrease and must be retroactive from the effective date of the
267.22 rate decrease.

267.23 (b) The annual rate decreases described in this section must be provided to:

267.24 (1) home and community-based waivered services for persons with developmental
267.25 disabilities or related conditions, including consumer-directed community supports, under
267.26 Minnesota Statutes, section 256B.501;

267.27 (2) home and community-based waivered services for the elderly, including
267.28 consumer-directed community supports, under Minnesota Statutes, section 256B.0915;

267.29 (3) waivered services under community alternatives for disabled individuals,
267.30 including consumer-directed community supports, under Minnesota Statutes, section
267.31 256B.49;

267.32 (4) community alternative care waivered services, including consumer-directed
267.33 community supports, under Minnesota Statutes, section 256B.49;

268.1 (5) traumatic brain injury waivered services, including consumer-directed
268.2 community supports, under Minnesota Statutes, section 256B.49;
268.3 (6) nursing services and home health services under Minnesota Statutes, section
268.4 256B.0625, subdivision 6a;
268.5 (7) personal care services and qualified professional supervision of personal care
268.6 services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;
268.7 (8) private duty nursing services under Minnesota Statutes, section 256B.0625,
268.8 subdivision 7;
268.9 (9) day training and habilitation services for adults with developmental disabilities
268.10 or related conditions under Minnesota Statutes, sections 252.40 to 252.46, including the
268.11 additional cost of rate adjustments on day training and habilitation services, provided as a
268.12 social service under Minnesota Statutes, section 256M.60;
268.13 (10) alternative care services under Minnesota Statutes, section 256B.0913;
268.14 (11) the group residential housing supplementary service rate under Minnesota
268.15 Statutes, section 256I.05, subdivision 1a;
268.16 (12) semi-independent living services (SILS) under Minnesota Statutes, section
268.17 252.275, including SILS funding under county social services grants formerly funded
268.18 under Minnesota Statutes, chapter 256I;
268.19 (13) community support services for deaf and hard-of-hearing adults with mental
268.20 illness who use or wish to use sign language as their primary means of communication
268.21 under Minnesota Statutes, section 256.01, subdivision 2; and deaf and hard-of-hearing
268.22 grants under Minnesota Statutes, sections 256C.233 and 256C.25; Laws 1985, chapter 9;
268.23 and Laws 1997, First Special Session chapter 5, section 20;
268.24 (14) consumer support grants under Minnesota Statutes, section 256.476;
268.25 (15) family support grants under Minnesota Statutes, section 252.32;
268.26 (16) aging grants under Minnesota Statutes, sections 256.975 to 256.977, 256B.0917,
268.27 and 256B.0928;
268.28 (17) disability linkage line grants under Minnesota Statutes, section 256.01,
268.29 subdivision 24; and
268.30 (18) housing access grants under Minnesota Statutes, section 256B.0658.
268.31 (c) A managed care plan receiving state payments for the services in this section
268.32 must include these decreases in their payments to providers effective on January 1
268.33 following the effective date of the rate decrease.

268.34 Sec. 77. **RECOMMENDATIONS FOR PERSONAL CARE ASSISTANCE**
268.35 **SERVICES CHANGES AND CONSULTATION WITH STAKEHOLDERS.**

269.1 The commissioner shall consult with representatives of interested stakeholders
269.2 beginning in July 2009 to examine and develop recommendations for the personal care
269.3 assistance services program, including recommendations to streamline the home care
269.4 ratings and assignment of units of service to eligible recipients. The recommendations
269.5 shall include proposed changes, alternative services, and costs for those whose services
269.6 will change, as well as personal care assistance program data for public reporting.
269.7 The recommendations are to result in a reduction of spending growth as authorized
269.8 by the legislature in personal care assistance services beginning January 1, 2011. The
269.9 recommendations shall be provided to the chairs and ranking minority members of the
269.10 legislative committees having jurisdiction over health and human services by January
269.11 15, 2010.

269.12 Sec. 78. **ESTABLISHING A SINGLE SET OF STANDARDS.**

269.13 (a) The commissioner of human services shall consult with disability service
269.14 providers, advocates, counties, and consumer families to develop a single set of standards
269.15 governing services for people with disabilities receiving services under the home and
269.16 community-based waiver services program to replace all or portions of existing laws and
269.17 rules including, but not limited to, data practices, licensure of facilities and providers,
269.18 background studies, reporting of maltreatment of minors, reporting of maltreatment of
269.19 vulnerable adults, and the psychotropic medication checklist. The standards must:
269.20 (1) enable optimum consumer choice;
269.21 (2) be consumer driven;
269.22 (3) link services to individual needs and life goals;
269.23 (4) be based on quality assurance and individual outcomes;
269.24 (5) utilize the people closest to the recipient, who may include family, friends, and
269.25 health and service providers, in conjunction with the recipient's risk management plan to
269.26 assist the recipient or the recipient's guardian in making decisions that meet the recipient's
269.27 needs in a cost-effective manner and assure the recipient's health and safety;
269.28 (6) utilize person-centered planning; and
269.29 (7) maximize federal financial participation.
269.30 (b) The commissioner may consult with existing stakeholder groups convened under
269.31 the commissioner's authority, including the home and community-based expert services
269.32 panel established by the commissioner in 2008, to meet all or some of the requirements
269.33 of this section.

270.1 (c) The commissioner shall provide the reports and plans required by this section to
270.2 the legislative committees and budget divisions with jurisdiction over health and human
270.3 services policy and finance by January 15, 2012.

270.4 Sec. 79. **COMMON SERVICE MENU FOR HOME AND COMMUNITY-BASED**
270.5 **WAIVER PROGRAMS.**

270.6 The commissioner of human services shall confer with representatives of recipients,
270.7 advocacy groups, counties, providers, and health plans to develop and update a common
270.8 service menu for home and community-based waiver programs. The commissioner may
270.9 consult with existing stakeholder groups convened under the commissioner's authority to
270.10 meet all or some of the requirements of this section.

270.11 Sec. 80. **INTERMEDIATE CARE FACILITIES FOR PERSONS WITH**
270.12 **DEVELOPMENTAL DISABILITIES REPORT.**

270.13 The commissioner of human services shall consult with providers and advocates of
270.14 intermediate care facilities for persons with developmental disabilities to monitor progress
270.15 made in response to the commissioner's December 15, 2008, report to the legislature
270.16 regarding intermediate care facilities for persons with developmental disabilities.

270.17 Sec. 81. **HOUSING OPTIONS.**

270.18 The commissioner of human services, in consultation with the commissioner of
270.19 administration and the Minnesota Housing Finance Agency, and representatives of
270.20 counties, residents' advocacy groups, consumers of housing services, and provider
270.21 agencies shall explore ways to maximize the availability and affordability of housing
270.22 choices available to persons with disabilities or who need care assistance due to other
270.23 health challenges. A goal shall also be to minimize state physical plant costs in order to
270.24 serve more persons with appropriate program and care support. Consideration shall be
270.25 given to:

270.26 (1) improved access to rent subsidies;

270.27 (2) use of cooperatives, land trusts, and other limited equity ownership models;

270.28 (3) the desirability of the state acquiring an ownership interest or promoting the
270.29 use of publicly owned housing;

270.30 (4) promoting more choices in the market for accessible housing that meets the
270.31 needs of persons with physical challenges; and

270.32 (5) what consumer ownership models, if any, are appropriate.

271.1 The commissioner shall provide a written report on the findings of the evaluation of
271.2 housing options to the chairs and ranking minority members of the house of representatives
271.3 and senate standing committees with jurisdiction over health and human services policy
271.4 and funding by December 15, 2010. This report shall replace the November 1, 2010,
271.5 annual report by the commissioner required in Minnesota Statutes, sections 256B.0916,
271.6 subdivision 7, and 256B.49, subdivision 21.

271.7 Sec. 82. **REVIEW OF ELIGIBILITY.**

271.8 A county may utilize an eligibility review panel comprised of the county social
271.9 services director or designee, a county commissioner, and a social worker to review the
271.10 eligibility of each person currently receiving services under Minnesota Statutes, sections
271.11 256B.0659, 256B.092, and 256B.49. If a person currently receiving services is found to
271.12 be ineligible, the county must discontinue the inappropriately received services to that
271.13 person. The commissioner of human services may provide technical assistance to the
271.14 counties in redetermining eligibility for these programs.

271.15 **EFFECTIVE DATE.** This section is effective the day following final enactment.

271.16 Sec. 83. **REVISOR'S INSTRUCTION.**

271.17 Subdivision 1. **Renumbering of Minnesota Statutes, section 256B.0652,**
271.18 **authorization and review of home care services.** (a) The revisor of statutes shall
271.19 renumber each section of Minnesota Statutes listed in column A with the number in
271.20 column B.

271.21	Column A	Column B
271.22	256B.0652, subdivision 3	256B.0652, subdivision 14
271.23	256B.0651, subdivision 6, paragraph (a)	256B.0652, subdivision 3
271.24	256B.0651, subdivision 6, paragraph (b)	256B.0652, subdivision 4
271.25	256B.0651, subdivision 6, paragraph (c)	256B.0652, subdivision 7
271.26	256B.0651, subdivision 7, paragraph (a)	256B.0652, subdivision 8
271.27	256B.0651, subdivision 7, paragraph (b)	256B.0652, subdivision 14
271.28	256B.0651, subdivision 8	256B.0652, subdivision 9
271.29	256B.0651, subdivision 9	256B.0652, subdivision 10
271.30	256B.0651, subdivision 11	256B.0652, subdivision 11
271.31	256B.0654, subdivision 2	256B.0652, subdivision 5
271.32	256B.0655, subdivision 4	256B.0652, subdivision 6

271.33 (b) The revisor of statutes shall make necessary cross-reference changes in statutes
271.34 and rules consistent with the renumbering in paragraph (a). The Department of Human
271.35 Services shall assist the revisor with any cross-reference changes. The revisor may make

272.1 changes necessary to correct the punctuation, grammar, or structure of the remaining text
272.2 to conform with the intent of the renumbering in paragraph (a).

272.3 Subd. 2. **Renumbering personal care assistance services.** The revisor of statutes
272.4 shall replace any reference to Minnesota Statutes, section 256B.0655 with section
272.5 256B.0659, wherever it appears in statutes or rules. The revisor shall correct any cross
272.6 reference changes that are necessary as a result of this section. The Department of Human
272.7 Services shall assist the revisor in making these changes, and if necessary, shall draft a
272.8 corrections bill with changes for introduction in the 2010 legislative session. The revisor
272.9 may make changes to punctuation, grammar, or sentence structure to preserve the integrity
272.10 of statutes and effectuate the intention of this section.

272.11 Sec. 84. **REPEALER.**

272.12 (a) Minnesota Statutes 2008, sections 256B.0655, subdivisions 1, 1a, 1c, 1d, 1e,
272.13 1f, 1g, 1h, 1i, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, and 13; and 256B.071, subdivisions 1, 2, 3,
272.14 and 4, are repealed.

272.15 (b) Laws 1988, chapter 689, section 251, is repealed effective July 1, 2009.

272.16 (c) Minnesota Statutes 2008, sections 256B.19, subdivision 1d; and 256B.431,
272.17 subdivision 23, are repealed effective May 1, 2009.

272.18 **ARTICLE 10**

272.19 **STATE-COUNTY RESULTS, ACCOUNTABILITY, AND SERVICE**
272.20 **DELIVERY REFORM ACT**

272.21 Section 1. **[402A.01] CITATION.**

272.22 Sections 402A.01 to 402A.50 may be cited as the "State-County Results,
272.23 Accountability, and Service Delivery Reform Act."

272.24 Sec. 2. **[402A.10] DEFINITIONS.**

272.25 Subdivision 1. **Terms defined.** For the purposes of this chapter, the terms defined in
272.26 this subdivision have the meanings given.

272.27 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human
272.28 services.

272.29 Subd. 3. **Council.** "Council" means the Council on State-County Results,
272.30 Accountability, and Service Delivery Redesign established in section 402A.40.

272.31 Subd. 4. **Essential human services programs.** "Essential human services
272.32 programs" means assistance and services to recipients or potential recipients of public

273.1 welfare and other services delivered by counties that are mandated in state law that are
273.2 to be available in all counties of the state.

273.3 Subd. 5. **Redesign.** "Redesign" means the State-County Results, Accountability,
273.4 and Service Delivery Redesign under this chapter.

273.5 Subd. 6. **Service delivery authority.** "Service delivery authority" means a single
273.6 county, or group of counties operating by execution of a joint powers agreement under
273.7 section 471.59 or other contractual agreement, that has voluntarily chosen by resolution of
273.8 the county board of commissioners to participate in the redesign under this chapter.

273.9 Subd. 7. **Steering committee.** "Steering committee" means the Steering Committee
273.10 on Performance and Outcome Reforms.

273.11 **EFFECTIVE DATE.** This section is effective the day following final enactment.

273.12 Sec. 3. **[402A.15] STEERING COMMITTEE ON PERFORMANCE AND**
273.13 **OUTCOME REFORMS.**

273.14 Subdivision 1. **Duties.** (a) The Steering Committee on Performance and Outcome
273.15 Reforms shall develop a uniform process to establish and review performance and outcome
273.16 standards for all essential human services programs based on the current level of resources
273.17 available, and to develop appropriate reporting measures and a uniform accountability
273.18 process for responding to a county's or human service authority's failure to make adequate
273.19 progress on achieving performance measures. The accountability process shall focus on
273.20 the performance measures rather than inflexible implementation requirements.

273.21 (b) The steering committee shall:

273.22 (1) by November 1, 2009, establish an agreed upon list of essential services;

273.23 (2) by January 10, 2010, develop and recommend to the legislature a uniform,
273.24 graduated process for responding to a county's failure to make adequate progress on
273.25 achieving performance measures, including recommendations for the specific measures
273.26 and penalties to be imposed; and

273.27 (3) by December 15, 2009, establish a schedule to complete program reviews of all
273.28 essential services within three years, evaluate and establish performance measures and
273.29 goals based on those measures, modify the reporting system, and review the distribution
273.30 of state and federal funds for those services. The funding recommendations shall take into
273.31 consideration program demand and the unique differences of local areas in geography and
273.32 the populations served. Priority shall be given to services with the greatest variation in
273.33 availability and greatest administrative demands. The schedule shall be published on the
273.34 agency Web site and reported to the legislative committees with jurisdiction over health
273.35 and human services.

274.1 (c) As far as possible, the performance measures, reporting system, and distribution
274.2 formulas shall be consistent across program areas. The development of performance
274.3 measures shall consider the manner in which data will be collected and performance will
274.4 be reported. An estimate of increased or decreased state and local administrative costs
274.5 in collecting and reporting outcomes shall be addressed when performance measures
274.6 are established. The steering committee shall take into consideration that the goal of
274.7 implementing changes to program monitoring and reporting the progress toward achieving
274.8 outcomes is to significantly minimize the cost of administrative requirements and to
274.9 allow funds freed by reduced administrative expenditures to be used to provide additional
274.10 services, allow flexibility in service design and management, and focus energies on
274.11 achieving program and client outcomes.

274.12 (d) In making its recommendations, the steering committee shall consider input from
274.13 the council established in section 402A.40. The steering committee shall review the
274.14 measurable goals established under section 402A.30, subdivision 2, paragraph (b), and
274.15 consider whether they may be applied as statewide performance outcomes.

274.16 (e) The steering committee shall form work groups that include persons who provide
274.17 or receive essential services and representatives of organizations who advocate on behalf
274.18 of those persons.

274.19 (f) By January 15 of each year starting January 15, 2010, the steering committee
274.20 shall report to the governor and legislative committees with jurisdiction over health and
274.21 human services its recommendations for performance measures, a reporting system, and
274.22 funding distribution formulas. The steering committee shall also recommend statutory
274.23 provisions, rules and requirements, and reports that should be repealed or eliminated. In
274.24 addition, the commissioner shall post quarterly updates on the progress of the steering
274.25 committee on the department Web site.

274.26 Subd. 2. **Composition.** (a) The steering committee shall include:

274.27 (1) the commissioner of human services, or designee;

274.28 (2) three county commissioners, representative of rural, suburban, and urban
274.29 counties, selected by the Association of Minnesota Counties;

274.30 (3) three county directors of human services, representative of rural, suburban,
274.31 and urban counties, selected by the Minnesota Association of County Social Service
274.32 Administrators; and

274.33 (4) five clients or client advocates representing different populations receiving
274.34 services from the Department of Human Services, who are appointed by the commissioner.

275.1 (b) The commissioner, or designee, and a county commissioner shall serve as
275.2 cochairs of the committee. The committee shall be convened within 60 days of final
275.3 enactment of this legislation.
275.4 (c) State agency staff shall serve as informational resources and staff to the steering
275.5 committee. Statewide county associations shall assemble county program data as required.
275.6 (d) To promote information sharing and coordination between the steering committee
275.7 and council, one of the county representatives from paragraph (a), clause (2), and one of the
275.8 county representatives from paragraph (a), clause (3), must also serve as a representative
275.9 on the council under section 402A.40, subdivision 1, paragraph (b), clause (5) or (6).

275.10 **EFFECTIVE DATE.** This section is effective the day following final enactment.

275.11 Sec. 4. **[402A.20] STATE-COUNTY RESULTS, ACCOUNTABILITY, AND**
275.12 **SERVICE DELIVERY REDESIGN.**

275.13 The State-County Results, Accountability, and Service Delivery Redesign is
275.14 established to authorize implementation of methods and procedures for administering
275.15 assistance and services to recipients or potential recipients of public welfare and other
275.16 services delivered by counties which encourage greater transparency, more effective
275.17 governance, and innovation through the use of flexibility and performance measurement.

275.18 Sec. 5. **[402A.30] DESIGNATION OF SERVICE DELIVERY AUTHORITY.**

275.19 Subdivision 1. **Establishment.** A county or consortium of counties may establish
275.20 a service delivery authority to redesign the delivery of some or all essential services,
275.21 or other services as appropriate.
275.22 Subd. 2. **New state-county governance framework.** (a) Upon recommendation
275.23 of the council and approval of the commissioner, a single county with a population over
275.24 55,000, or two or more counties meeting the criteria in subdivision 4 may, by resolution of
275.25 their county boards of commissioners, establish a service delivery authority having the
275.26 composition, powers, and duties agreed upon. These counties may, by agreement entered
275.27 into through action of their bodies, jointly or cooperatively exercise any power common to
275.28 the contracting parties in carrying out their duties under current law, including, but not
275.29 limited to, chapters 245 to 267, 393, and 402. Participating county boards shall establish
275.30 acceptable ways of apportioning the cost of the services.
275.31 (b) To establish a service delivery authority, each participating county and the
275.32 state must enter into the following binding agreements to establish a joint state-county
275.33 governance framework:

276.1 (1) a governance agreement which defines the scope of essential services or other
276.2 services over which the service delivery authority has jurisdiction, and the respective
276.3 authority, powers, roles, and responsibilities of the state and service delivery authorities.
276.4 Each service delivery authority shall designate a single administrative structure to oversee
276.5 the delivery of services over which the service delivery authority has jurisdiction. As part
276.6 of the governance agreement, the service delivery authority shall be held accountable for
276.7 achieving measurable goals as defined in the performance agreement under clause (2). The
276.8 state and participating counties shall identify in the agreement the waivers from statutory
276.9 requirements that are needed to ensure greater local control and flexibility to determine the
276.10 most cost-effective means of achieving specified measurable goals. The commissioner
276.11 shall grant the identified waivers, subject to clause (2). The governance agreement shall
276.12 set forth the terms under which a county may withdraw from participation;

276.13 (2) a performance agreement which defines measurable goals in key operational areas
276.14 that the service delivery authority is expected to achieve. This agreement must identify
276.15 the dependencies and other requirements necessary for the service delivery authority to
276.16 achieve the measurable goals as defined in the performance agreement. The dependencies
276.17 and requirements may include, but are not limited to, specific resource commitments of
276.18 the state and the service delivery authority, and funding or expenditure flexibility.

276.19 The performance goals must, at a minimum, satisfy performance outcomes
276.20 recommended by the steering committee and enacted into law; and

276.21 (3) a service level agreement which specifies the expectations and responsibilities
276.22 of the state and the service delivery authority regarding administrative and information
276.23 technology support necessary to achieve the measurable goals specified in the performance
276.24 agreement under clause (2). The service level agreement shall set forth a reasonable level
276.25 of targeted reductions in overhead and administrative costs for each county participating
276.26 in the service delivery authority.

276.27 (c) After January 1, 2010, each county board in Minnesota shall vote to determine
276.28 whether the county intends to participate in a service delivery authority under this chapter.
276.29 Counties may withdraw from participation as set forth in the governance agreement, but
276.30 no county may withdraw except under the following conditions:

276.31 (1) the county shall submit written notification to the council after August 1 in the
276.32 preceding calendar year in which the county wishes to withdraw; and

276.33 (2) if a county wishing to withdraw has received an appropriation from the state for
276.34 costs related to the county's participation in the redesign, those funds must be repaid. If a
276.35 county withdraws after participating in the redesign for:

276.36 (i) one year or less, the county must repay 75 percent of the money appropriated;

277.1 (ii) more than one year but less than two years, the county must repay 50 percent of
277.2 the money appropriated;
277.3 (iii) two years or more but less than three years, the county must repay 25 percent of
277.4 the money appropriated; or
277.5 (iv) three years or more, the county is not required to repay the appropriation.
277.6 The commissioner may waive the repayment requirement in clause (2).
277.7 (d) Nothing in this chapter precludes local governments from utilizing sections
277.8 465.81 and 465.82 to establish procedures for local governments to merge, with the
277.9 consent of the voters. Any agreement under subdivision 2, paragraph (b), must be
277.10 governed by this chapter. Nothing in this chapter limits the authority of a county board
277.11 to enter into contractual agreements for services not covered by the provisions of the
277.12 redesign with other agencies or with other units of government.
277.13 Subd. 3. **Duties.** (a) The service delivery authority shall:
277.14 (1) carry out the responsibilities required of local agencies under chapter 393 and
277.15 human service boards under chapter 402;
277.16 (2) manage the public resources devoted to human services and other public services
277.17 delivered or purchased by the counties that are subsidized or regulated by the Department
277.18 of Human Services under chapter 245 or 267;
277.19 (3) employ staff to assist in carrying out the redesign;
277.20 (4) develop and maintain a continuity of operations plan to ensure the continued
277.21 operation or resumption of essential human services functions in the event of any business
277.22 interruption according to local, state, and federal emergency planning requirements;
277.23 (5) receive and expend funds received for the redesign;
277.24 (6) plan and deliver services directly or through contract with other governmental
277.25 or nongovernmental providers;
277.26 (7) rent, purchase, sell, and otherwise dispose of real and personal property as
277.27 necessary to carry out the redesign; and
277.28 (8) carry out any other service designated as a responsibility of a county.
277.29 (b) Each service delivery authority certified under subdivision 4 shall designate a
277.30 single administrative structure that has the powers and duties assigned to the service
277.31 delivery authority.
277.32 Subd. 4. **Certification of service delivery authority.** The council shall recommend
277.33 certification of a county or consortium of counties as a service delivery authority to the
277.34 commissioner of human services if:
277.35 (1) the conditions in subdivision 2, paragraphs (a) and (b), are met; and
277.36 (2) the county or consortium of counties are:

278.1 (i) a single county with a population of 55,000 or more;
278.2 (ii) a consortium of counties with a total combined population of 55,000 or more and
278.3 the counties comprising the consortium are in reasonable geographic proximity;
278.4 (iii) four or more counties in reasonable geographic proximity without regard to
278.5 population; or
278.6 (iv) a single county or consortium of counties meeting the criteria for exemption
278.7 from minimum population standards in this subdivision and subdivision 6.
278.8 Subd. 5. **Single county service delivery authority.** For counties with populations
278.9 over 55,000, the board of county commissioners may be the service delivery authority
278.10 and retain existing authority under law. Counties with populations over 55,000 that serve
278.11 as their own service delivery authority may enter into shared services arrangements with
278.12 other service delivery authorities or smaller counties. These shared services arrangements
278.13 may include, but are not limited to, human services, corrections, public health, veterans
278.14 planning, human resources, program development and operations, training, technical
278.15 systems, joint purchasing, and consultative services or direct services to transient, special
278.16 needs, or low-incidence populations.
278.17 Subd. 6. **Exemption.** The council may recommend that the commissioner of
278.18 human services exempt a single county or multicounty service delivery authority from the
278.19 minimum population standard in this subdivision if that service delivery authority can
278.20 demonstrate that it can otherwise meet the requirements of this chapter.
278.21 Subd. 7. **Commissioner remedies.** The commissioner may submit to the council
278.22 a recommendation of remedies for performance improvement for any service delivery
278.23 authority not meeting the measurable goals agreed upon in performance agreements
278.24 under subdivision 2, paragraph (b). This provision does not preclude other powers of the
278.25 commissioner of human services to remedy county performance issues in a county or
278.26 counties not certified as a service delivery authority.

278.27 Sec. 6. **[402A.40] COUNCIL.**

278.28 Subdivision 1. **Council.** (a) A State-County Results, Accountability, and Service
278.29 Delivery Redesign Council is established. The council is responsible for review of the
278.30 redesign and must be convened by the commissioner of human services. Appointed council
278.31 members must be appointed by their respective agencies, associations, or governmental
278.32 units by November 1, 2009. The council shall be cochaired by the commissioner of human
278.33 services, or designee, and a county representative from paragraph (b), clause (5) or (6),
278.34 appointed by the Association of Minnesota Counties. Recommendations of the council

279.1 must be approved by a majority of the council members. The provisions of section 15.059
279.2 do not apply to this council, and this council does not expire.
279.3 (b) The council must consist of the following members:
279.4 (1) one representative from the governor's office;
279.5 (2) from the house of representatives, one member of the majority party and one
279.6 member of the minority party, appointed by the speaker of the house;
279.7 (3) from the senate, one member of the majority party and one member of the
279.8 minority party, appointed by the senate majority leader;
279.9 (4) the commissioner of human services, or designee, and two employees from
279.10 the department;
279.11 (5) two county commissioners appointed by the Association of Minnesota Counties;
279.12 (6) two county representatives appointed by the Minnesota Association of County
279.13 Social Service Administrators;
279.14 (7) one representative appointed by AFSCME; and
279.15 (8) one representative appointed by the Teamsters.
279.16 (c) Administrative support to the council may be provided by the Association of
279.17 Minnesota Counties and affiliates.
279.18 (d) Member agencies and associations are responsible for initial and subsequent
279.19 appointments to the council.
279.20 Subd. 2. **Council duties.** (a) The council shall:
279.21 (1) provide oversight of administration of the redesign;
279.22 (2) recommend the approval of waivers from statutory requirements, administrative
279.23 rules, and standards necessary to achieve the requirements of the agreements under
279.24 section 402A.30, subdivision 2, paragraph (b), to the commissioner of human services
279.25 or other appropriate entity, for counties certified as service delivery authorities under
279.26 section 402A.30;
279.27 (3) recommend approval of the agreements in section 402A.30, subdivision 2,
279.28 paragraph (b), to the commissioner of human services and ensure the consistency of the
279.29 agreements with the performance standards recommended by the steering committee and
279.30 enacted by the legislature;
279.31 (4) recommend certification of a county or consortium of counties as a service
279.32 delivery authority to the commissioner of human services;
279.33 (5) recommend approval of shared services arrangements under section 402A.30,
279.34 subdivision 5;
279.35 (6) establish a process to take public input on a proposed service delivery authority
279.36 and the governance framework;

280.1 (7) form work groups as necessary to carry out the duties of the council under the
280.2 redesign; and
280.3 (8) establish a process for the mediation of conflicts among participating counties or
280.4 between participating counties and the commissioner of human services.
280.5 (b) In order to carry out the provisions of the redesign, and to effectuate the
280.6 agreements established under section 402A.30, subdivision 2, paragraph (b), the
280.7 commissioner of human services shall exercise authority under section 256.01, subdivision
280.8 2, paragraph (l), including seeking all necessary waivers. The commissioner of human
280.9 services has authority to approve shared service arrangements as defined in section
280.10 402A.30, subdivision 5.

280.11 **EFFECTIVE DATE.** This section is effective the day following final enactment.

280.12 Sec. 7. **[402A.50]; PRIVATE SECTOR FUNDING.**

280.13 The council may support stakeholder agencies, if not otherwise prohibited by law, to
280.14 separately or jointly seek and receive funds to provide expert technical assistance to the
280.15 council, the council's work group, and any sub-work groups for executing the provisions
280.16 of the redesign.

280.17 Sec. 8. **APPROPRIATION.**

280.18 $350,000 is appropriated for the biennium beginning July 1, 2009, from the general
280.19 fund to the Council on State-County Results, Accountability, and Service Delivery
280.20 Redesign, for the purposes of the State-County Results, Accountability, and Service
280.21 Delivery Reform Act under Minnesota Statutes, sections 402A.01 to 402A.50. The
280.22 council shall establish a methodology for distributing funds to certified service delivery
280.23 authorities for the purposes of carrying out the requirements of the redesign.

280.24 **ARTICLE 11**

280.25 **PUBLIC HEALTH**

280.26 Section 1. Minnesota Statutes 2008, section 103I.208, subdivision 2, is amended to
280.27 read:

280.28 Subd. 2. **Permit fee.** The permit fee to be paid by a property owner is:

280.29 (1) for a water supply well that is not in use under a maintenance permit, $175
280.30 annually;

280.31 (2) for construction of a monitoring well, $215, which includes the state core
280.32 function fee;

281.1 (3) for a monitoring well that is unsealed under a maintenance permit, $175 annually;
281.2 (4) for a monitoring well owned by a federal agency, state agency, or local unit of
281.3 government that is unsealed under a maintenance permit, $50 annually. "Local unit of
281.4 government" means a statutory or home rule charter city, town, county, or soil and water
281.5 conservation district, watershed district, an organization formed for the joint exercise of
281.6 powers under section 471.59, a board of health or community health board, or other
281.7 special purpose district or authority with local jurisdiction in water and related land
281.8 resources management;
281.9 (5) for monitoring wells used as a leak detection device at a single motor fuel retail
281.10 outlet, a single petroleum bulk storage site excluding tank farms, or a single agricultural
281.11 chemical facility site, the construction permit fee is $215, which includes the state core
281.12 function fee, per site regardless of the number of wells constructed on the site, and
281.13 the annual fee for a maintenance permit for unsealed monitoring wells is $175 per site
281.14 regardless of the number of monitoring wells located on site;
281.15 ~~(5)~~ (6) for a groundwater thermal exchange device, in addition to the notification fee
281.16 for water supply wells, $215, which includes the state core function fee;
281.17 ~~(6)~~ (7) for a vertical heat exchanger with less than ten tons of heating/cooling
281.18 capacity, $215;
281.19 (8) for a vertical heat exchanger with ten to 50 tons of heating/cooling capacity, $425;
281.20 (9) for a vertical heat exchanger with greater than 50 tons of heating/cooling
281.21 capacity, $650;
281.22 ~~(7)~~ (10) for a dewatering well that is unsealed under a maintenance permit, $175
281.23 annually for each dewatering well, except a dewatering project comprising more than five
281.24 dewatering wells shall be issued a single permit for $875 annually for dewatering wells
281.25 recorded on the permit; and
281.26 ~~(8)~~ (11) for an elevator boring, $215 for each boring.

281.27 Sec. 2. Minnesota Statutes 2008, section 144.121, subdivision 1a, is amended to read:
281.28 Subd. 1a. **Fees for ionizing radiation-producing equipment.** (a) A facility with
281.29 ionizing radiation-producing equipment must pay an annual initial or annual renewal
281.30 registration fee consisting of a base facility fee of ~~$66~~ $100 and an additional fee for
281.31 each radiation source, as follows:

281.32	(1) medical or veterinary equipment	$ ~~53~~ 100
281.33	(2) dental x-ray equipment	$ ~~33~~ 40
281.34	~~(3) accelerator~~	~~$ 66~~
281.35	~~(4) radiation therapy equipment~~	~~$ 66~~

~~(5)~~ (3) x-ray equipment not used on humans or animals	$ ~~53~~ 100
~~(6)~~ (4) devices with sources of ionizing radiation not used on humans or animals	$ ~~53~~ 100

(b) A facility with radiation therapy and accelerator equipment must pay an annual registration fee of $500. A facility with an industrial accelerator must pay an annual registration fee of $150.

(c) Electron microscopy equipment is exempt from the registration fee requirements of this section.

Sec. 3. Minnesota Statutes 2008, section 144.121, subdivision 1b, is amended to read:

Subd. 1b. **Penalty fee for late registration.** Applications for initial or renewal registrations submitted to the commissioner after the time specified by the commissioner shall be accompanied by ~~a penalty fee of $20~~ an amount equal to 25 percent of the fee due in addition to the fees prescribed in subdivision 1a.

Sec. 4. Minnesota Statutes 2008, section 144.1222, subdivision 1a, is amended to read:

Subd. 1a. **Fees.** All plans and specifications for public pool and spa construction, installation, or alteration or requests for a variance that are submitted to the commissioner according to Minnesota Rules, part 4717.3975, shall be accompanied by the appropriate fees. All public pool construction plans submitted for review after January 1, 2009, must be certified by a professional engineer registered in the state of Minnesota. If the commissioner determines, upon review of the plans, that inadequate fees were paid, the necessary additional fees shall be paid before plan approval. For purposes of determining fees, a project is defined as a proposal to construct or install a public pool, spa, special purpose pool, or wading pool and all associated water treatment equipment and drains, gutters, decks, water recreation features, spray pads, and those design and safety features that are within five feet of any pool or spa. The commissioner shall charge the following fees for plan review and inspection of public pools and spas and for requests for variance from the public pool and spa rules:

(1) each pool, ~~$800~~ $1,500;

(2) each spa pool, ~~$500~~ $800;

(3) each slide, ~~$400~~ $600;

(4) projects valued at $250,000 or more, the greater of the sum of the fees in clauses (1), (2), and (3) or 0.5 percent of the documented estimated project cost to a maximum fee of ~~$10,000~~ $15,000;

(5) alterations to an existing pool without changing the size or configuration of the pool, ~~$400~~ $600;

(6) removal or replacement of pool disinfection equipment only, ~~$75~~ $100; and

(7) request for variance from the public pool and spa rules, $500.

Sec. 5. Minnesota Statutes 2008, section 144.125, subdivision 1, is amended to read:

Subdivision 1. **Duty to perform testing.** It is the duty of (1) the administrative officer or other person in charge of each institution caring for infants 28 days or less of age, (2) the person required in pursuance of the provisions of section 144.215, to register the birth of a child, or (3) the nurse midwife or midwife in attendance at the birth, to arrange to have administered to every infant or child in its care tests for heritable and congenital disorders according to subdivision 2 and rules prescribed by the state commissioner of health. Testing and the recording and reporting of test results shall be performed at the times and in the manner prescribed by the commissioner of health. The commissioner shall charge a fee so that the total of fees collected will approximate the costs of conducting the tests and implementing and maintaining a system to follow-up infants with heritable or congenital disorders, including hearing loss detected through the early hearing detection and intervention program under section 144.966. The fee is ~~$101~~ $105 per specimen. Costs associated with capital expenditures and the development of new procedures may be prorated over a three-year period when calculating the amount of the fees.

EFFECTIVE DATE. This section is effective July 1, 2010.

Sec. 6. Minnesota Statutes 2008, section 144.72, subdivision 1, is amended to read:

Subdivision 1. **~~Permits~~ License required.** The state commissioner of health is authorized to issue ~~permits for the operation of youth camps which are required to obtain the permits~~ a license according to chapter 157.

Sec. 7. Minnesota Statutes 2008, section 144.72, subdivision 3, is amended to read:

Subd. 3. **Issuance of ~~permits~~ license.** If the commissioner should determine from the application that the health and safety of the persons using the camp will be properly safeguarded, the commissioner may, prior to actual inspection of the camp, issue the ~~permit~~ license in writing. ~~No fee shall be charged for the permit.~~ The ~~permit~~ license shall be posted in a conspicuous place on the premises occupied by the camp.

Sec. 8. Minnesota Statutes 2008, section 144.9501, is amended by adding a subdivision to read:

Subd. 8a. **Disclosure pamphlet.** "Disclosure pamphlet" means the EPA pamphlet titled "Renovate Right: Important Lead Hazard Information for Families, Child Care Providers and Schools" developed under section 406(a) of the Toxic Substance Control Act.

Sec. 9. Minnesota Statutes 2008, section 144.9501, subdivision 22b, is amended to read:

Subd. 22b. **Lead sampling technician.** "Lead sampling technician" means an individual who performs clearance inspections for ~~nonabatement or nonorder lead hazard reduction~~ renovation sites~~,~~ and lead dust sampling ~~in other settings, or visual assessment for deteriorated paint~~ for nonabatement sites, and who is registered with the commissioner under section 144.9505.

Sec. 10. Minnesota Statutes 2008, section 144.9501, subdivision 26a, is amended to read:

Subd. 26a. **Regulated lead work.** (a) "Regulated lead work" means:

(1) abatement;

(2) interim controls;

(3) a clearance inspection;

(4) a lead hazard screen;

(5) a lead inspection;

(6) a lead risk assessment;

(7) lead project designer services;

(8) lead sampling technician services; ~~or~~

(9) swab team services~~.~~;

(10) renovation activities; or

(11) activities performed to comply with lead orders issued by a board of health.

(b) Regulated lead work does not include abatement, interim controls, swab team services, or renovation activities that disturb painted surfaces that total no more than:

~~(1) activities such as remodeling, renovation, installation, rehabilitation, or landscaping activities, the primary intent of which is to remodel, repair, or restore a structure or dwelling, rather than to permanently eliminate lead hazards, even though these activities may incidentally result in a reduction in lead hazards; or~~

~~(2) interim control activities that are not performed as a result of a lead order and that do not disturb painted surfaces that total more than:~~

~~(i)~~ (1) 20 square feet (two square meters) on exterior surfaces; or

285.1 ~~(ii) two~~ (2) six square feet (~~0.2~~ 0.6 square meters) in an interior room~~; or~~.
285.2 ~~(iii) ten percent of the total surface area on an interior or exterior type of component~~
285.3 ~~with a small surface area.~~

285.4 Sec. 11. Minnesota Statutes 2008, section 144.9501, is amended by adding a
285.5 subdivision to read:
285.6 Subd. 26b. **Renovation.** "Renovation" means the modification of any affected
285.7 property that results in the disturbance of painted surfaces, unless that activity is performed
285.8 as an abatement. A renovation performed for the purpose of converting a building or part
285.9 of a building into an affected property is a renovation under this subdivision.

285.10 Sec. 12. Minnesota Statutes 2008, section 144.9505, subdivision 1g, is amended to
285.11 read:
285.12 Subd. 1g. **Certified lead firm.** ~~A person within the state intending to directly~~
285.13 ~~perform or cause to be performed through subcontracting or similar delegation any~~
285.14 ~~regulated lead work shall first obtain certification from the commissioner~~ A person who
285.15 employs individuals to perform regulated lead work outside of the person's property must
285.16 obtain certification as a lead firm. The certificate must be in writing, contain an expiration
285.17 date, be signed by the commissioner, and give the name and address of the person to
285.18 whom it is issued. The certification fee is $100, is nonrefundable, and must be submitted
285.19 with each application. The certificate or a copy of the certificate must be readily available
285.20 at the worksite for review by the contracting entity, the commissioner, and other public
285.21 health officials charged with the health, safety, and welfare of the state's citizens.

285.22 Sec. 13. Minnesota Statutes 2008, section 144.9505, subdivision 4, is amended to read:
285.23 Subd. 4. **Notice of regulated lead work.** (a) At least five working days before
285.24 starting work at each regulated lead worksite, the person performing the regulated lead
285.25 work shall give written notice to the commissioner and the appropriate board of health.
285.26 (b) This provision does not apply to lead hazard screen, lead inspection, lead risk
285.27 assessment, lead sampling technician, renovation, or lead project design activities.

285.28 Sec. 14. Minnesota Statutes 2008, section 144.9508, subdivision 2, is amended to read:
285.29 Subd. 2. **Regulated lead work standards and methods.** (a) The commissioner
285.30 shall adopt rules establishing regulated lead work standards and methods in accordance
285.31 with the provisions of this section, for lead in paint, dust, drinking water, and soil in
285.32 a manner that protects public health and the environment for all residences, including

286.1 residences also used for a commercial purpose, child care facilities, playgrounds, and
286.2 schools.

286.3 (b) In the rules required by this section, the commissioner shall require lead hazard
286.4 reduction of intact paint only if the commissioner finds that the intact paint is on a
286.5 chewable or lead-dust producing surface that is a known source of actual lead exposure to
286.6 a specific individual. The commissioner shall prohibit methods that disperse lead dust into
286.7 the air that could accumulate to a level that would exceed the lead dust standard specified
286.8 under this section. The commissioner shall work cooperatively with the commissioner
286.9 of administration to determine which lead hazard reduction methods adopted under this
286.10 section may be used for lead-safe practices including prohibited practices, preparation,
286.11 disposal, and cleanup. The commissioner shall work cooperatively with the commissioner
286.12 of the Pollution Control Agency to develop disposal procedures. In adopting rules under
286.13 this section, the commissioner shall require the best available technology for regulated
286.14 lead work methods, paint stabilization, and repainting.

286.15 (c) The commissioner of health shall adopt regulated lead work standards and
286.16 methods for lead in bare soil in a manner to protect public health and the environment.
286.17 The commissioner shall adopt a maximum standard of 100 parts of lead per million in
286.18 bare soil. The commissioner shall set a soil replacement standard not to exceed 25 parts
286.19 of lead per million. Soil lead hazard reduction methods shall focus on erosion control
286.20 and covering of bare soil.

286.21 (d) The commissioner shall adopt regulated lead work standards and methods for
286.22 lead in dust in a manner to protect the public health and environment. Dust standards
286.23 shall use a weight of lead per area measure and include dust on the floor, on the window
286.24 sills, and on window wells. Lead hazard reduction methods for dust shall focus on dust
286.25 removal and other practices which minimize the formation of lead dust from paint, soil, or
286.26 other sources.

286.27 (e) The commissioner shall adopt lead hazard reduction standards and methods for
286.28 lead in drinking water both at the tap and public water supply system or private well
286.29 in a manner to protect the public health and the environment. The commissioner may
286.30 adopt the rules for controlling lead in drinking water as contained in Code of Federal
286.31 Regulations, title 40, part 141. Drinking water lead hazard reduction methods may include
286.32 an educational approach of minimizing lead exposure from lead in drinking water.

286.33 (f) The commissioner of the Pollution Control Agency shall adopt rules to ensure that
286.34 removal of exterior lead-based coatings from residences and steel structures by abrasive
286.35 blasting methods is conducted in a manner that protects health and the environment.

(g) All regulated lead work standards shall provide reasonable margins of safety that are consistent with more than a summary review of scientific evidence and an emphasis on overprotection rather than underprotection when the scientific evidence is ambiguous.

(h) No unit of local government shall have an ordinance or regulation governing regulated lead work standards or methods for lead in paint, dust, drinking water, or soil that require a different regulated lead work standard or method than the standards or methods established under this section.

(i) Notwithstanding paragraph (h), the commissioner may approve the use by a unit of local government of an innovative lead hazard reduction method which is consistent in approach with methods established under this section.

(j) The commissioner shall adopt rules for issuing lead orders required under section 144.9504, rules for notification of abatement or interim control activities requirements, and other rules necessary to implement sections 144.9501 to 144.9512.

(k) The commissioner shall adopt rules consistent with section 402(c)(3) of the Toxic Substances Control Act to ensure that renovation in a pre-1978 affected property where a child or pregnant female resides is conducted in a manner that protects health and the environment.

(l) The commissioner shall adopt rules consistent with sections 406(a) and 406(b) of the Toxic Substances Control Act.

Sec. 15. Minnesota Statutes 2008, section 144.9508, subdivision 3, is amended to read:

Subd. 3. **Licensure and certification.** The commissioner shall adopt rules to license lead supervisors, lead workers, lead project designers, lead inspectors, ~~and~~ lead risk assessors, and lead sampling technicians. The commissioner shall also adopt rules requiring certification of firms that perform regulated lead work ~~and rules requiring registration of lead sampling technicians~~. The commissioner shall require periodic renewal of licenses~~,~~ and certificates~~, and registrations~~ and shall establish the renewal periods.

Sec. 16. Minnesota Statutes 2008, section 144.9508, subdivision 4, is amended to read:

Subd. 4. **Lead training course.** The commissioner shall establish by rule requirements for training course providers and the renewal period for each lead-related training course required for certification or licensure. The commissioner shall establish criteria in rules for the content and presentation of training courses intended to qualify trainees for licensure under subdivision 3. The commissioner shall establish criteria in rules for the content and presentation of training courses for lead ~~interim control workers~~ renovation and lead sampling technicians. Training course permit fees shall be

288.1 nonrefundable and must be submitted with each application in the amount of $500 for an
288.2 initial training course, $250 for renewal of a permit for an initial training course, $250 for
288.3 a refresher training course, and $125 for renewal of a permit of a refresher training course.

288.4 Sec. 17. Minnesota Statutes 2008, section 144.9512, subdivision 2, is amended to read:
288.5 Subd. 2. **Grants; administration.** Within the limits of the available appropriation,
288.6 the commissioner shall make grants to ~~a~~ nonprofit ~~organization currently operating the~~
288.7 ~~CLEARCorps lead hazard reduction project~~ organizations to train workers to provide lead
288.8 screening, education, outreach, and swab team services for residential property. Projects
288.9 that provide Americorps funding or positions, or leverage matching funds, as part of the
288.10 delivery of the services must be given priority for the grant funds.

288.11 Sec. 18. Minnesota Statutes 2008, section 144.966, is amended by adding a subdivision
288.12 to read:
288.13 Subd. 3a. **Support services to families.** The commissioner shall contract with
288.14 a nonprofit organization to provide support and assistance to families with children
288.15 who are deaf or have a hearing loss. The family support provided must include direct
288.16 parent-to-parent assistance and information on communication, educational, and medical
288.17 options. The commissioner shall give preference to a nonprofit organization that has the
288.18 ability to provide these services throughout the state.

288.19 Sec. 19. Minnesota Statutes 2008, section 144.97, subdivision 2, is amended to read:
288.20 Subd. 2. ~~**Certification**~~ **Accreditation.** ~~"Certification" means written~~
288.21 ~~acknowledgment of a laboratory's demonstrated capability to perform tests for a specific~~
288.22 ~~purpose~~ "Accreditation" means written acknowledgment that a laboratory has the
288.23 policies, procedures, equipment, and practices to produce reliable data in the analysis of
288.24 environmental samples.

288.25 **EFFECTIVE DATE.** This section is effective July 1, 2009.

288.26 Sec. 20. Minnesota Statutes 2008, section 144.97, subdivision 4, is amended to read:
288.27 Subd. 4. ~~**Contract**~~ **Commercial laboratory.** "~~Contract~~ Commercial laboratory"
288.28 means a laboratory that performs tests on samples on a contract or fee-for-service basis.

288.29 **EFFECTIVE DATE.** This section is effective July 1, 2009.

289.1 Sec. 21. Minnesota Statutes 2008, section 144.97, is amended by adding a subdivision
289.2 to read:
289.3 Subd. 5a. **Field of testing.** "Field of testing" means the combination of analyte,
289.4 method, matrix, and test category for which a laboratory may hold accreditation.

289.5 **EFFECTIVE DATE.** This section is effective July 1, 2009.

289.6 Sec. 22. Minnesota Statutes 2008, section 144.97, subdivision 6, is amended to read:
289.7 Subd. 6. **Laboratory.** "Laboratory" means the state, a person, corporation, or other
289.8 entity, including governmental, that examines, analyzes, or tests samples in a specified
289.9 physical location.

289.10 **EFFECTIVE DATE.** This section is effective July 1, 2009.

289.11 Sec. 23. Minnesota Statutes 2008, section 144.97, is amended by adding a subdivision
289.12 to read:
289.13 Subd. 8. **Test category.** "Test category" means the combination of program and
289.14 category as provided by section 144.98, subdivisions 3, paragraph (b), clauses (1) to (10),
289.15 and 3a, paragraph (a), clauses (1) to (5).

289.16 **EFFECTIVE DATE.** This section is effective July 1, 2009.

289.17 Sec. 24. Minnesota Statutes 2008, section 144.98, subdivision 1, is amended to read:
289.18 Subdivision 1. **Authorization.** The commissioner of health ~~may certify~~ shall
289.19 accredit environmental laboratories ~~that test environmental samples~~ according to national
289.20 standards developed using a consensus process as established by Circular A-119,
289.21 published by the United States Office of Management and Budget.

289.22 **EFFECTIVE DATE.** This section is effective July 1, 2009.

289.23 Sec. 25. Minnesota Statutes 2008, section 144.98, subdivision 2, is amended to read:
289.24 Subd. 2. **Rules and standards.** The commissioner may adopt rules to ~~implement~~
289.25 ~~this section, including:~~ carry out the commissioner's responsibilities under the national
289.26 standards specified in subdivisions 1 and 2a.
289.27 ~~(1) procedures, requirements, and fee adjustments for laboratory certification,~~
289.28 ~~including provisional status and recertification;~~
289.29 ~~(2) standards and fees for certificate approval, suspension, and revocation;~~
289.30 ~~(3) standards for environmental samples;~~

~~(4) analysis methods that assure reliable test results;~~

~~(5) laboratory quality assurance, including internal quality control, proficiency testing, and personnel training; and~~

~~(6) criteria for recognition of certification programs of other states and the federal government.~~

EFFECTIVE DATE. This section is effective July 1, 2009.

Sec. 26. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision to read:

Subd. 2a. **Standards.** The commissioner shall accredit laboratories according to the most current environmental laboratory accreditation standards under subdivision 1 and as accepted by the accreditation bodies recognized by the National Environmental Laboratory Accreditation Program (NELAP) of the NELAC Institute.

EFFECTIVE DATE. This section is effective July 1, 2009.

Sec. 27. Minnesota Statutes 2008, section 144.98, subdivision 3, is amended to read:

Subd. 3. **Annual fees.** (a) An application for ~~certification~~ accreditation under subdivision ~~1~~ 6 must be accompanied by the ~~biennial fee~~ annual fees specified in this subdivision. The ~~fees are for~~ annual fees include:

(1) base ~~certification~~ accreditation fee, ~~$1,600~~ $1,500;

(2) sample preparation techniques ~~fees~~ fee, ~~$100~~ $200 per technique; ~~and~~

(3) an administrative fee for laboratories located outside this state, $3,750; and

(4) test category ~~certification~~ fees~~:~~.

~~Test Category~~	~~Certification Fee~~
~~Clean water program bacteriology~~	~~$800~~
~~Safe drinking water program bacteriology~~	~~$800~~
~~Clean water program inorganic chemistry~~	~~$800~~
~~Safe drinking water program inorganic chemistry~~	~~$800~~
~~Clean water program chemistry metals~~	~~$1,200~~
~~Safe drinking water program chemistry metals~~	~~$1,200~~
~~Resource conservation and recovery program chemistry metals~~	~~$1,200~~
~~Clean water program volatile organic compounds~~	~~$1,500~~
~~Safe drinking water program volatile organic compounds~~	~~$1,500~~
~~Resource conservation and recovery program volatile organic compounds~~	~~$1,500~~
~~Underground storage tank program volatile organic compounds~~	~~$1,500~~
~~Clean water program other organic compounds~~	~~$1,500~~
~~Safe drinking water program other organic compounds~~	~~$1,500~~

291.1	~~Resource conservation and recovery program other organic compounds~~	~~$1,500~~
291.2	~~Clean water program radiochemistry~~	~~$2,500~~
291.3	~~Safe drinking water program radiochemistry~~	~~$2,500~~
291.4	~~Resource conservation and recovery program agricultural contaminants~~	~~$2,500~~
291.5	~~Resource conservation and recovery program emerging contaminants~~	~~$2,500~~

291.6 (b) ~~Laboratories located outside of this state that require an on-site inspection shall be~~
291.7 ~~assessed an additional $3,750 fee.~~ For the programs in subdivision 3a, the commissioner
291.8 may accredit laboratories for fields of testing under the categories listed in clauses (1) to
291.9 (10) upon completion of the application requirements provided by subdivision 6 and
291.10 receipt of the fees for each category under each program that accreditation is requested.
291.11 The categories offered and related fees include:

291.12 (1) microbiology, $450;

291.13 (2) inorganics, $450;

291.14 (3) metals, $1,000;

291.15 (4) volatile organics, $1,300;

291.16 (5) other organics, $1,300;

291.17 (6) radiochemistry, $1,500;

291.18 (7) emerging contaminants, $1,500;

291.19 (8) agricultural contaminants, $1,250;

291.20 (9) toxicity (bioassay), $1,000; and

291.21 (10) physical characterization, $250.

291.22 (c) The total ~~biennial certification~~ annual fee includes the base fee, the sample
291.23 preparation techniques fees, the test category fees per program, and, when applicable, ~~the~~
291.24 ~~on-site inspection fee~~ an administrative fee for out-of-state laboratories.

291.25 ~~(d) Fees must be set so that the total fees support the laboratory certification program.~~
291.26 ~~Direct costs of the certification service include program administration, inspections, the~~
291.27 ~~agency's general support costs, and attorney general costs attributable to the fee function.~~

291.28 ~~(e) A change fee shall be assessed if a laboratory requests additional analytes~~
291.29 ~~or methods at any time other than when applying for or renewing its certification. The~~
291.30 ~~change fee is equal to the test category certification fee for the analyte.~~

291.31 ~~(f) A variance fee shall be assessed if a laboratory requests and is granted a variance~~
291.32 ~~from a rule adopted under this section. The variance fee is $500 per variance.~~

291.33 ~~(g) Refunds or credits shall not be made for analytes or methods requested but~~
291.34 ~~not approved.~~

291.35 ~~(h) Certification of a laboratory shall not be awarded until all fees are paid.~~

292.1 Sec. 28. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision
292.2 to read:

292.3 Subd. 3a. **Available programs, categories, and analytes.** (a) The commissioner
292.4 shall accredit laboratories that test samples under the following programs:

292.5 (1) the clean water program, such as compliance monitoring under the federal Clean
292.6 Water Act, and ambient monitoring of surface and groundwater, or analysis of biological
292.7 tissue;

292.8 (2) the safe drinking water program, including compliance monitoring under the
292.9 federal Safe Drinking Water Act, and the state requirements for monitoring private wells;

292.10 (3) the resource conservation and recovery program, including federal and state
292.11 requirements for monitoring solid and hazardous wastes, biological tissue, leachates, and
292.12 groundwater monitoring wells not intended as drinking water sources;

292.13 (4) the underground storage tank program; and

292.14 (5) the clean air program, including air and emissions testing under the federal Clean
292.15 Air Act, and state and federal requirements for vapor intrusion monitoring.

292.16 (b) The commissioner shall maintain and publish a list of analytes available for
292.17 accreditation. The list must be reviewed at least once every six months and the changes
292.18 published in the State Register and posted on the program's Web site. The commissioner
292.19 shall publish the notification of changes and review comments on the changes no less than
292.20 30 days from the date the list is published.

292.21 Sec. 29. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision
292.22 to read:

292.23 Subd. 3b. **Additional fees.** (a) Laboratories located outside of this state that require
292.24 an on-site assessment more frequent than once every two years must pay an additional
292.25 assessed fee of $3,000 per assessment for each additional on-site assessment conducted.
292.26 The laboratory must pay the fee within 15 business days of receiving the commissioner's
292.27 notification that an on-site assessment is required. The commissioner may conduct
292.28 additional on-site assessments to determine a laboratory's continued compliance with
292.29 the standards provided in subdivision 2a.

292.30 (b) A late fee of $200 shall be added to the annual fee for accredited laboratories
292.31 submitting renewal applications to the commissioner after November 1.

292.32 (c) A change fee shall be assessed if a laboratory requests additional fields of testing
292.33 at any time other than when initially applying for or renewing its accreditation. A change
292.34 fee does not apply for applications to add fields of testing for new analytes in response
292.35 to the published notice under subdivision 3a, paragraph (b), if the laboratory holds valid

293.1 accreditation for the changed test category and applies for additional analytes within the
293.2 same test category. The change fee is equal to the applicable test category fee for the
293.3 field of testing requested. An application that requests accreditation of multiple fields of
293.4 testing within a test category requires a single payment of the applicable test category fee
293.5 per application submitted.

293.6 (d) A variance fee shall be assessed if a laboratory requests a variance from a
293.7 standard provided in subdivision 2a. The variance fee is $500 per variance.

293.8 (e) The commissioner shall assess a fee for changes to laboratory information
293.9 regarding ownership, name, address, or personnel. Laboratories must submit changes
293.10 through the application process under subdivision 6. The information update fee is $250
293.11 per application.

293.12 (f) Fees must be set so that the total fees support the laboratory accreditation
293.13 program. Direct costs of the accreditation service include program administration,
293.14 assessments, the agency's general support costs, and attorney general costs attributable
293.15 to the fee function.

293.16 Sec. 30. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision
293.17 to read:

293.18 Subd. 3c. **Refunds and nonpayment.** Refunds or credits shall not be made for
293.19 applications received but not approved. Accreditation of a laboratory shall not be awarded
293.20 until all fees are paid.

293.21 Sec. 31. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision
293.22 to read:

293.23 Subd. 6. **Application.** (a) Laboratories seeking accreditation must apply on a form
293.24 provided by the commissioner, include the laboratory's procedures and quality manual,
293.25 and pay the applicable fees.

293.26 (b) Laboratories may be fixed-base or mobile. The commissioner shall accredit
293.27 mobile laboratories individually and require a vehicle identification number, license
293.28 plate number, or other uniquely identifying information in addition to the application
293.29 requirements of paragraph (a).

293.30 (c) Laboratories maintained on separate properties, even though operated under the
293.31 same management or ownership, must apply separately. Laboratories with more than one
293.32 building on the same or adjoining properties do not need to submit a separate application.

293.33 (d) The commissioner may accredit laboratories located out-of-state. Accreditation
293.34 for out-of-state laboratories may be obtained directly from the commissioner following

294.1 the requirements in paragraph (a), or out-of-state laboratories may be accredited through
294.2 a reciprocal agreement if the laboratory:
294.3 (1) is accredited by a NELAP-recognized accreditation body for those fields of
294.4 testing in which the laboratory requests accreditation from the commissioner;
294.5 (2) submits an application and documentation according to this subdivision; and
294.6 (3) submits a current copy of the laboratory's unexpired accreditation from a
294.7 NELAP-recognized accreditation body showing the fields of accreditation for which the
294.8 laboratory is currently accredited.
294.9 (e) Under the conflict of interest determinations provided in section 43A.38,
294.10 subdivision 6, clause (a), the commissioner shall not accredit governmental laboratories
294.11 operated by agencies of the executive branch of the state. If accreditation is required,
294.12 laboratories operated by agencies of the executive branch of the state must apply for
294.13 accreditation through any other NELAP-recognized accreditation body.

294.14 **EFFECTIVE DATE.** This section is effective July 1, 2009.

294.15 Sec. 32. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision
294.16 to read:
294.17 Subd. 6a. **Implementation and effective date.** All laboratories must comply with
294.18 standards under this section by July 1, 2009. Fees under subdivisions 3 and 3b apply to
294.19 applications received and accreditations issued after June 30, 2009. Accreditations issued
294.20 on or before June 30, 2009, shall expire upon their current expiration date.

294.21 Sec. 33. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision
294.22 to read:
294.23 Subd. 7. **Initial accreditation and annual accreditation renewal.** (a) The
294.24 commissioner shall issue or renew accreditation after receipt of the completed application
294.25 and documentation required in this section, provided the laboratory maintains compliance
294.26 with the standards specified in subdivision 2a, and attests to the compliance on the
294.27 application form.
294.28 (b) The commissioner shall prorate the fees in subdivision 3 for laboratories
294.29 applying for accreditation after December 31. The fees are prorated on a quarterly basis
294.30 beginning with the quarter in which the commissioner receives the completed application
294.31 from the laboratory.
294.32 (c) Applications for renewal of accreditation must be received by November 1 and
294.33 no earlier than October 1 of each year. The commissioner shall send annual renewal

295.1 notices to laboratories 90 days before expiration. Failure to receive a renewal notice does
295.2 not exempt laboratories from meeting the annual November 1 renewal date.
295.3 (d) The commissioner shall issue all accreditations for the calendar year for which
295.4 the application is made, and the accreditation shall expire on December 31 of that year.
295.5 (e) The accreditation of any laboratory that fails to submit a renewal application
295.6 and fees to the commissioner expires automatically on December 31 without notice or
295.7 further proceeding. Any person who operates a laboratory as accredited after expiration of
295.8 accreditation or without having submitted an application and paid the fees is in violation
295.9 of the provisions of this section and is subject to enforcement action under sections
295.10 144.989 to 144.993, the Health Enforcement Consolidation Act. A laboratory with expired
295.11 accreditation may reapply under subdivision 6.

295.12 **EFFECTIVE DATE.** This section is effective July 1, 2009.

295.13 Sec. 34. Minnesota Statutes 2008, section 144.99, subdivision 1, is amended to read:
295.14 Subdivision 1. **Remedies available.** The provisions of chapters 103I and 157 and
295.15 sections 115.71 to 115.77; 144.12, subdivision 1, paragraphs (1), (2), (5), (6), (10), (12),
295.16 (13), (14), and (15); 144.1201 to 144.1204; 144.121; 144.1222; 144.35; 144.381 to
295.17 144.385; 144.411 to 144.417; 144.495; 144.71 to 144.74; 144.9501 to 144.9512; 144.97
295.18 to 144.98; 144.992; 326.70 to 326.785; 327.10 to 327.131; and 327.14 to 327.28 and
295.19 all rules, orders, stipulation agreements, settlements, compliance agreements, licenses,
295.20 registrations, certificates, and permits adopted or issued by the department or under any
295.21 other law now in force or later enacted for the preservation of public health may, in
295.22 addition to provisions in other statutes, be enforced under this section.

295.23 **EFFECTIVE DATE.** This section is effective July 1, 2009.

295.24 Sec. 35. Minnesota Statutes 2008, section 153A.17, is amended to read:

295.25 **153A.17 EXPENSES; FEES.**

295.26 (a) The expenses for administering the certification requirements including the
295.27 complaint handling system for certified hearing aid dispensers in sections 153A.14 and
295.28 153A.15 and the Consumer Information Center under section 153A.18 must be paid
295.29 from initial application and examination fees, renewal fees, penalties, and fines. ~~All~~
295.30 ~~fees are nonrefundable.~~
295.31 (b) The certificate application fee is $350, the examination fee is $250 for the
295.32 written portion and $250 for the practical portion each time one or the other is taken,
295.33 and the trainee application fee is $200. The penalty fee for late submission of a renewal

296.1 application is $200. The fee for verification of certification to other jurisdictions or entities
296.2 is $25. All fees are nonrefundable.

296.3 (c) All fees, penalties, and fines received must be deposited in the state government
296.4 special revenue fund. The commissioner may prorate the certification fee for new
296.5 applicants based on the number of quarters remaining in the annual certification period.

296.6 (d) The fees charged by the commissioner must reflect the actual costs of
296.7 administering the program under paragraph (a). Fees must not be increased to cover the
296.8 costs associated with investigating allegations against uncertified hearing aid dispensers.

296.9 Sec. 36. Minnesota Statutes 2008, section 157.15, is amended by adding a subdivision
296.10 to read:

296.11 Subd. 20. **Youth camp.** "Youth camp" has the meaning given in section 144.71,
296.12 subdivision 2.

296.13 Sec. 37. Minnesota Statutes 2008, section 157.16, is amended to read:

296.14 **157.16 LICENSES REQUIRED; FEES.**

296.15 Subdivision 1. **License required annually.** A license is required annually for every
296.16 person, firm, or corporation engaged in the business of conducting a food and beverage
296.17 service establishment, for-profit youth camp, hotel, motel, lodging establishment, public
296.18 pool, or resort. Any person wishing to operate a place of business licensed in this
296.19 section shall first make application, pay the required fee specified in this section, and
296.20 receive approval for operation, including plan review approval. ~~Seasonal and temporary~~
296.21 ~~food stands and~~ Special event food stands are not required to submit plans. Nonprofit
296.22 organizations operating a special event food stand with multiple locations at an annual
296.23 one-day event shall be issued only one license. Application shall be made on forms
296.24 provided by the commissioner and shall require the applicant to state the full name and
296.25 address of the owner of the building, structure, or enclosure, the lessee and manager of the
296.26 food and beverage service establishment, hotel, motel, lodging establishment, public pool,
296.27 or resort; the name under which the business is to be conducted; and any other information
296.28 as may be required by the commissioner to complete the application for license.

296.29 Subd. 2. **License renewal.** Initial and renewal licenses for all food and beverage
296.30 service establishments, for-profit youth camps, hotels, motels, lodging establishments,
296.31 public pools, and resorts shall be issued ~~for the calendar year for which application is~~
296.32 ~~made and shall expire on December 31 of such year~~ on an annual basis. Any person
296.33 who operates a place of business after the expiration date of a license or without having
296.34 submitted an application and paid the fee shall be deemed to have violated the provisions

of this chapter and shall be subject to enforcement action, as provided in the Health Enforcement Consolidation Act, sections 144.989 to 144.993. In addition, a penalty of ~~$50~~ $60 shall be added to the total of the license fee for any food and beverage service establishment operating without a license as a mobile food unit, a seasonal temporary or seasonal permanent food stand, or a special event food stand, and a penalty of ~~$100~~ $120 shall be added to the total of the license fee for all restaurants, food carts, hotels, motels, lodging establishments, for-profit youth camps, public pools, and resorts operating without a license for a period of up to 30 days. A late fee of ~~$300~~ $360 shall be added to the license fee for establishments operating more than 30 days without a license.

Subd. 2a. **Food manager certification.** An applicant for certification or certification renewal as a food manager must submit to the commissioner a ~~$28~~ $35 nonrefundable certification fee payable to the Department of Health. The commissioner shall issue a duplicate certificate to replace a lost, destroyed, or mutilated certificate if the applicant submits a completed application on a form provided by the commissioner for a duplicate certificate and pays $20 to the department for the cost of duplication.

Subd. 3. **Establishment fees; definitions.** (a) The following fees are required for food and beverage service establishments, for-profit youth camps, hotels, motels, lodging establishments, public pools, and resorts licensed under this chapter. Food and beverage service establishments must pay the highest applicable fee under paragraph (d), clause (1), (2), (3), or (4), and establishments serving alcohol must pay the highest applicable fee under paragraph (d), clause (6) or (7). The license fee for new operators previously licensed under this chapter for the same calendar year is one-half of the appropriate annual license fee, plus any penalty that may be required. The license fee for operators opening on or after October 1 is one-half of the appropriate annual license fee, plus any penalty that may be required.

(b) All food and beverage service establishments, except special event food stands, and all hotels, motels, lodging establishments, public pools, and resorts shall pay an annual base fee of $150.

(c) A special event food stand shall pay a flat fee of ~~$40~~ $50 annually. "Special event food stand" means a fee category where food is prepared or served in conjunction with celebrations, county fairs, or special events from a special event food stand as defined in section 157.15.

(d) In addition to the base fee in paragraph (b), each food and beverage service establishment, other than a special event food stand, and each hotel, motel, lodging establishment, public pool, and resort shall pay an additional annual fee for each fee

category, additional food service, or required additional inspection specified in this paragraph:

(1) Limited food menu selection, ~~$50~~ $60. "Limited food menu selection" means a fee category that provides one or more of the following:

(i) prepackaged food that receives heat treatment and is served in the package;

(ii) frozen pizza that is heated and served;

(iii) a continental breakfast such as rolls, coffee, juice, milk, and cold cereal;

(iv) soft drinks, coffee, or nonalcoholic beverages; or

(v) cleaning for eating, drinking, or cooking utensils, when the only food served is prepared off site.

(2) Small establishment, including boarding establishments, ~~$100~~ $120. "Small establishment" means a fee category that has no salad bar and meets one or more of the following:

(i) possesses food service equipment that consists of no more than a deep fat fryer, a grill, two hot holding containers, and one or more microwave ovens;

(ii) serves dipped ice cream or soft serve frozen desserts;

(iii) serves breakfast in an owner-occupied bed and breakfast establishment;

(iv) is a boarding establishment; or

(v) meets the equipment criteria in clause (3), item (i) or (ii), and has a maximum patron seating capacity of not more than 50.

(3) Medium establishment, ~~$260~~ $310. "Medium establishment" means a fee category that meets one or more of the following:

(i) possesses food service equipment that includes a range, oven, steam table, salad bar, or salad preparation area;

(ii) possesses food service equipment that includes more than one deep fat fryer, one grill, or two hot holding containers; or

(iii) is an establishment where food is prepared at one location and served at one or more separate locations.

Establishments meeting criteria in clause (2), item (v), are not included in this fee category.

(4) Large establishment, ~~$460~~ $540. "Large establishment" means either:

(i) a fee category that (A) meets the criteria in clause (3), items (i) or (ii), for a medium establishment, (B) seats more than 175 people, and (C) offers the full menu selection an average of five or more days a week during the weeks of operation; or

(ii) a fee category that (A) meets the criteria in clause (3), item (iii), for a medium establishment, and (B) prepares and serves 500 or more meals per day.

299.1 (5) Other food and beverage service, including food carts, mobile food units,
299.2 seasonal temporary food stands, and seasonal permanent food stands, ~~$50~~ $60.
299.3 (6) Beer or wine table service, ~~$50~~ $60. "Beer or wine table service" means a fee
299.4 category where the only alcoholic beverage service is beer or wine, served to customers
299.5 seated at tables.
299.6 (7) Alcoholic beverage service, other than beer or wine table service, ~~$135~~ $165.
299.7 "Alcohol beverage service, other than beer or wine table service" means a fee
299.8 category where alcoholic mixed drinks are served or where beer or wine are served from
299.9 a bar.
299.10 (8) Lodging per sleeping accommodation unit, ~~$8~~ $10, including hotels, motels,
299.11 lodging establishments, and resorts, up to a maximum of ~~$800~~ $1,000. "Lodging per
299.12 sleeping accommodation unit" means a fee category including the number of guest rooms,
299.13 cottages, or other rental units of a hotel, motel, lodging establishment, or resort; or the
299.14 number of beds in a dormitory.
299.15 (9) First public pool, ~~$180~~ $325; each additional public pool, ~~$100~~ $175. "Public
299.16 pool" means a fee category that has the meaning given in section 144.1222, subdivision 4.
299.17 (10) First spa, ~~$110~~ $175; each additional spa, ~~$50~~ $100. "Spa pool" means a fee
299.18 category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 9.
299.19 (11) Private sewer or water, ~~$50~~ $60. "Individual private water" means a fee
299.20 category with a water supply other than a community public water supply as defined in
299.21 Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with an
299.22 individual sewage treatment system which uses subsurface treatment and disposal.
299.23 (12) Additional food service, ~~$130~~ $150. "Additional food service" means a location
299.24 at a food service establishment, other than the primary food preparation and service area,
299.25 used to prepare or serve food to the public.
299.26 (13) Additional inspection fee, ~~$300~~ $360. "Additional inspection fee" means a
299.27 fee to conduct the second inspection each year for elementary and secondary education
299.28 facility school lunch programs when required by the Richard B. Russell National School
299.29 Lunch Act.
299.30 (e) A fee ~~of $350~~ for review of ~~the~~ construction plans must accompany the initial
299.31 license application for restaurants, hotels, motels, lodging establishments, ~~or~~ resorts ~~with~~
299.32 ~~five or more sleeping units.~~, seasonal food stands, and mobile food units. The fee for
299.33 this construction plan review is as follows:

	Service Area	Type	Fee
299.34	**Service Area**	**Type**	**Fee**
299.35	Food	limited food menu	$275
299.36		small establishment	$400

300.1		medium establishment	$450
300.2		large food establishment	$500
300.3		additional food service	$150
300.4	Transient food service	food cart	$250
300.5		seasonal permanent food stand	$250
300.6		seasonal temporary food stand	$250
300.7		mobile food unit	$350
300.8	Alcohol	beer or wine table service	$150
300.9		alcohol service from bar	$250
300.10	Lodging	less than 25 rooms	$375
300.11		25 to less than 100 rooms	$400
300.12		100 rooms or more	$500
300.13		less than five cabins	$350
300.14		five to less than ten cabins	$400
300.15		ten cabins or more	$450

300.16 (f) When existing food and beverage service establishments, hotels, motels, lodging
300.17 establishments, ~~or~~ resorts, seasonal food stands, and mobile food units are extensively
300.18 remodeled, a fee ~~of $250~~ must be submitted with the remodeling plans. ~~A fee of $250~~
300.19 ~~must be submitted for new construction or remodeling for a restaurant with a limited food~~
300.20 ~~menu selection, a seasonal permanent food stand, a mobile food unit, or a food cart, or for~~
300.21 ~~a hotel, motel, resort, or lodging establishment addition of less than five sleeping units.~~
300.22 The fee for this construction plan review is as follows:

	Service Area	**Type**	**Fee**
300.24	Food	limited food menu	$250
300.25		small establishment	$300
300.26		medium establishment	$350
300.27		large food establishment	$400
300.28		additional food service	$150
300.29	Transient food service	food cart	$250
300.30		seasonal permanent food stand	$250
300.31		seasonal temporary food stand	$250
300.32		mobile food unit	$250
300.33	Alcohol	beer or wine table service	$150
300.34		alcohol service from bar	$250
300.35	Lodging	less than 25 rooms	$250
300.36		25 to less than 100 rooms	$300
300.37		100 rooms or more	$450
300.38		less than five cabins	$250
300.39		five to less than ten cabins	$350
300.40		ten cabins or more	$400

(g) ~~Seasonal temporary food stands and~~ Special event food stands are not required to submit construction or remodeling plans for review.

(h) For-profit youth camp fee, $500.

Subd. 3a. **Statewide hospitality fee.** Every person, firm, or corporation that operates a licensed boarding establishment, food and beverage service establishment, seasonal temporary or permanent food stand, special event food stand, mobile food unit, food cart, resort, hotel, motel, or lodging establishment in Minnesota must submit to the commissioner a $35 annual statewide hospitality fee for each licensed activity. The fee for establishments licensed by the Department of Health is required at the same time the licensure fee is due. For establishments licensed by local governments, the fee is due by July 1 of each year.

Subd. 4. **Posting requirements.** Every food and beverage service establishment, for-profit youth camp, hotel, motel, lodging establishment, public pool, or resort must have the license posted in a conspicuous place at the establishment. Mobile food units, food carts, and seasonal temporary food stands shall be issued decals with the initial license and each calendar year with license renewals. The current license year decal must be placed on the unit or stand in a location determined by the commissioner. Decals are not transferable.

Sec. 38. Minnesota Statutes 2008, section 157.22, is amended to read:

157.22 EXEMPTIONS.

This chapter ~~shall not be construed to~~ does not apply to:

(1) interstate carriers under the supervision of the United States Department of Health and Human Services;

(2) any building constructed and primarily used for religious worship;

(3) any building owned, operated, and used by a college or university in accordance with health regulations promulgated by the college or university under chapter 14;

(4) any person, firm, or corporation whose principal mode of business is licensed under sections 28A.04 and 28A.05, is exempt at that premises from licensure as a food or beverage establishment; provided that the holding of any license pursuant to sections 28A.04 and 28A.05 shall not exempt any person, firm, or corporation from the applicable provisions of this chapter or the rules of the state commissioner of health relating to food and beverage service establishments;

(5) family day care homes and group family day care homes governed by sections 245A.01 to 245A.16;

(6) nonprofit senior citizen centers for the sale of home-baked goods;

(7) fraternal or patriotic organizations that are tax exempt under section 501(c)(3), 501(c)(4), 501(c)(6), 501(c)(7), 501(c)(10), or 501(c)(19) of the Internal Revenue Code of 1986, or organizations related to or affiliated with such fraternal or patriotic organizations. Such organizations may organize events at which home-prepared food is donated by organization members for sale at the events, provided:

(i) the event is not a circus, carnival, or fair;

(ii) the organization controls the admission of persons to the event, the event agenda, or both; and

(iii) the organization's licensed kitchen is not used in any manner for the event;

(8) food not prepared at an establishment and brought in by individuals attending a potluck event for consumption at the potluck event. An organization sponsoring a potluck event under this clause may advertise the potluck event to the public through any means. Individuals who are not members of an organization sponsoring a potluck event under this clause may attend the potluck event and consume the food at the event. Licensed food establishments other than schools cannot be sponsors of potluck events. A school may sponsor and hold potluck events in areas of the school other than the school's kitchen, provided that the school's kitchen is not used in any manner for the potluck event. For purposes of this clause, "school" means a public school as defined in section 120A.05, subdivisions 9, 11, 13, and 17, or a nonpublic school, church, or religious organization at which a child is provided with instruction in compliance with sections 120A.22 and 120A.24. Potluck event food shall not be brought into a licensed food establishment kitchen; ~~and~~

(9) a home school in which a child is provided instruction at home; and

(10) concession stands operated in conjunction with school-sponsored events on school property are exempt from the 21-day restriction.

Sec. 39. Minnesota Statutes 2008, section 327.14, is amended by adding a subdivision to read:

Subd. 9. **Special event recreational camping area.** "Special event recreational camping area" means a recreational camping area which operates no more than two times annually and for no more than 14 consecutive days.

Sec. 40. Minnesota Statutes 2008, section 327.15, is amended to read:

327.15 LICENSE REQUIRED; RENEWAL; ~~PLANS FOR EXPANSION~~ FEES.

Subdivision 1. **License required; plan review.** No person, firm or corporation shall establish, maintain, conduct or operate a manufactured home park or recreational camping

303.1 area within this state without first obtaining a an annual license therefor from the state
303.2 Department of Health. Any person wishing to obtain a license shall first make application,
303.3 pay the required fee specified in this section, and receive approval for operation, including
303.4 plan review approval. Application shall be made on forms provided by the commissioner
303.5 and shall require the applicant to state the full name and address of the owner of the
303.6 manufactured home park or recreational camping area, the name under which the business
303.7 is to be conducted, and any other information as may be required by the commissioner
303.8 to complete the application for license. Any person, firm, or corporation desiring to
303.9 operate either a manufactured home park or a recreational camping area on the same site
303.10 in connection with the other, need only obtain one license. A license shall expire and be
303.11 renewed as prescribed by the commissioner pursuant to section 144.122. The license shall
303.12 state the number of manufactured home sites and recreational camping sites allowed
303.13 according to state commissioner of health approval. No renewal license shall be issued if
303.14 the number of sites specified in the application exceeds those of the original application
303.15 The number of licensed sites shall not be increased unless the plans for expansion or
303.16 the construction for expansion are submitted and the expansion first approved by the
303.17 Department of Health. Any manufactured home park or recreational camping area located
303.18 in more than one municipality shall be dealt with as two separate manufactured home
303.19 parks or camping areas. The license shall be conspicuously displayed in the office of the
303.20 manufactured home park or camping area. The license is not transferable as to person
303.21 or place.

303.22 Subd. 2. **License renewal.** Initial and renewal licenses for all manufactured home
303.23 parks and recreational camping areas shall be issued annually and shall have an expiration
303.24 date included on the license. Any person who operates a manufactured home park or
303.25 recreational camping area after the expiration date of a license or without having submitted
303.26 an application and paid the fee shall be deemed to have violated the provisions of this
303.27 chapter and shall be subject to enforcement action, as provided in the Health Enforcement
303.28 Consolidation Act, sections 144.989 to 144.993. In addition, a penalty of $120 shall
303.29 be added to the total of the license fee for any manufactured home park or recreational
303.30 camping area operating without a license for a period of up to 30 days. A late fee of $360
303.31 shall be added to the license fee for any manufactured home park or recreational camping
303.32 area operating more than 30 days without a license.

303.33 Subd. 3. **Fees; manufactured home parks; recreational camping areas.** (a) The
303.34 following fees are required for manufactured home parks and recreational camping areas
303.35 licensed under this chapter. Recreational camping areas and manufactured home parks
303.36 must pay the highest applicable fee under paragraph (c). The license fee for new operators

304.1 of a manufactured home park or recreational camping area previously licensed under this
304.2 chapter for the same calendar year is one-half of the appropriate annual license fee, plus
304.3 any penalty that may be required. The license fee for operators opening on or after October
304.4 1 is one-half of the appropriate annual license fee, plus any penalty that may be required.

304.5 (b) All manufactured home parks and recreational camping areas, except special
304.6 event recreational camping areas, shall pay an annual base fee of $150 plus $4 for each
304.7 licensed site, except that any operator of a manufactured home park or recreational
304.8 camping area who is licensed under section 157.16 for the same location shall not be
304.9 required to pay the base fee.

304.10 (c) In addition to the fee in paragraph (b), each manufactured home park or
304.11 recreational camping area shall pay an additional annual fee for each fee category
304.12 specified in this paragraph:

304.13 (1) manufactured home parks and recreational camping areas with public swimming
304.14 pools and spas shall pay the appropriate fees specified in section 157.16; and

304.15 (2) individual private sewer or water, $60. "Individual private water" means a fee
304.16 category with a water supply other than a community public water supply as defined in
304.17 Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with an
304.18 individual sewage treatment system which uses subsurface treatment and disposal.

304.19 (d) The following fees must accompany a plan review application for initial
304.20 construction of a manufactured home park or recreational camping area for initial
304.21 construction of:

304.22 (1) less than 25 sites, $375;

304.23 (2) 25 to less than 100 sites, $400; and

304.24 (3) 100 or more sites, $500.

304.25 (e) The following fees must accompany a plan review application when an existing
304.26 manufactured home park or recreational camping area is expanded for expansion of:

304.27 (1) less than 25 sites, $250;

304.28 (2) 25 but less than 100 sites, $300; and

304.29 (3) 100 or more sites, $450.

304.30 Subd. 4. **Fees; special event recreational camping areas.** (a) The following fees
304.31 are required for special event recreational camping areas licensed under this chapter.

304.32 (b) All special event recreational camping areas shall pay an annual fee of $150 plus
304.33 $1 for each licensed site.

304.34 (c) A special event recreational camping area shall pay a late fee of $360 for failing
304.35 to obtain a license prior to operating.

305.1 (d) The following fees must accompany a plan review application for initial
305.2 construction of a special event recreational camping area for initial construction of:
305.3 (1) less than 25 special event recreational camping sites, $375;
305.4 (2) 25 to less than 100 sites, $400; and
305.5 (3) 100 or more sites, $500.
305.6 (e) The following fees must accompany a plan review application for expansion of a
305.7 special event recreational camping area for expansion of:
305.8 (1) less than 25 sites, $250;
305.9 (2) 25 but less than 100 sites, $300; and
305.10 (3) 100 or more sites, $450.

305.11 Sec. 41. Minnesota Statutes 2008, section 327.16, is amended to read:

305.12 **327.16 ~~LICENSE~~ PLAN REVIEW APPLICATION.**

305.13 Subdivision 1. **Made to state Department of Health.** The plan review application
305.14 for ~~license to operate and maintain~~ a manufactured home park or recreational camping
305.15 area shall be made to the state Department of Health, at such office and in such manner
305.16 as may be prescribed by that department.

305.17 Subd. 2. **Contents.** The ~~applicant for a primary license or annual license shall make~~
305.18 ~~application in writing~~ plan review application shall be made upon a form provided by the
305.19 state Department of Health setting forth:

305.20 (1) The full name and address of the applicant or applicants, or names and addresses
305.21 of the partners if the applicant is a partnership, or the names and addresses of the officers
305.22 if the applicant is a corporation.

305.23 (2) A legal description of the site, lot, field, or tract of land upon which the applicant
305.24 proposes to operate and maintain a manufactured home park or recreational camping area.

305.25 (3) The proposed and existing facilities on and about the site, lot, field, or tract of
305.26 land for the proposed construction or alteration and maintaining of a sanitary community
305.27 building for toilets, urinals, sinks, wash basins, slop-sinks, showers, drains, laundry
305.28 facilities, source of water supply, sewage, garbage and waste disposal; except that no
305.29 toilet facilities shall be required in any manufactured home park which permits only
305.30 manufactured homes equipped with toilet facilities discharging to water carried sewage
305.31 disposal systems; and method of fire and storm protection.

305.32 (4) The proposed method of lighting the structures and site, lot, field, or tract of land
305.33 upon which the manufactured home park or recreational camping area is to be located.

305.34 (5) The calendar months of the year which the applicant will operate the
305.35 manufactured home park or recreational camping area.

306.1 (6) Plans and drawings for new construction or alteration, including buildings, wells,
306.2 plumbing and sewage disposal systems.
306.3 Subd. 3. **~~Fees;~~ Approval.** The application for ~~the primary license~~ plan review shall
306.4 be submitted with all plans and specifications enumerated in subdivision 2, ~~and payment~~
306.5 ~~of a fee in an amount prescribed by the state commissioner of health pursuant to section~~
306.6 ~~144.122~~ and shall be accompanied by an approved zoning permit from the municipality or
306.7 county wherein the park is to be located, or a statement from the municipality or county
306.8 that it does not require an approved zoning permit. ~~The fee for the annual license shall be~~
306.9 ~~in an amount prescribed by the state commissioner of health pursuant to section 144.122.~~
306.10 ~~All license fees paid to the commissioner of health shall be turned over to the state~~
306.11 ~~treasury.~~ The fee submitted for the ~~primary license~~ plan review shall be retained by the
306.12 state even though the proposed project is not approved and a license is denied.
306.13 When construction has been completed in accordance with approved plans and
306.14 specifications the state commissioner of health shall promptly cause the manufactured
306.15 home park or recreational camping area and appurtenances thereto to be inspected. When
306.16 the inspection and report has been made and the state commissioner of health finds that
306.17 all requirements of sections 327.10, 327.11, 327.14 to 327.28, and such conditions of
306.18 health and safety as the state commissioner of health may require, have been met by
306.19 the applicant, the state commissioner of health shall forthwith issue the ~~primary~~ license
306.20 in the name of the state.
306.21 Subd. 4. **~~Sanitary facilities~~ Compliance with current state law.** ~~During the~~
306.22 ~~pendency of the application for such primary license any change in the sanitary or safety~~
306.23 ~~facilities of the intended manufactured home park or recreational camping area shall be~~
306.24 ~~immediately reported in writing to the state Department of Health through the office~~
306.25 ~~through which the application was made. If no objection is made by the state Department~~
306.26 ~~of Health to such change in such sanitary or safety facilities within 60 days of the date~~
306.27 ~~such change is reported, it shall be deemed to have the approval of the state Department of~~
306.28 ~~Health.~~ Any manufactured home park or recreational camping area must be constructed
306.29 and operated according to all applicable state electrical, fire, plumbing, and building codes.
306.30 Subd. 5. **Permit.** When the plans and specifications have been approved, the state
306.31 Department of Health shall issue an approval report permitting the applicant to construct
306.32 or make alterations upon a manufactured home park or recreational camping area and the
306.33 appurtenances thereto according to the plans and specifications presented.
306.34 Such approval does not relieve the applicant from securing building permits in
306.35 municipalities that require permits or from complying with any other municipal ordinance
306.36 or ordinances, applicable thereto, not in conflict with this statute.

307.1 Subd. 6. **Denial of construction.** If the application to construct or make alterations
307.2 upon a manufactured home park or recreational camping area and the appurtenances
307.3 thereto or a ~~primary~~ license to operate and maintain the same is denied by the state
307.4 commissioner of health, the commissioner shall so state in writing giving the reason
307.5 or reasons for denying the application. If the objections can be corrected the applicant
307.6 may amend the application and resubmit it for approval, and if denied the applicant may
307.7 appeal from the decision of the state commissioner of health as provided in section
307.8 144.99, subdivision 10.

307.9 Sec. 42. Minnesota Statutes 2008, section 327.20, subdivision 1, is amended to read:
307.10 Subdivision 1. **Rules.** No domestic animals or house pets of occupants of
307.11 manufactured home parks or recreational camping areas shall be allowed to run at large,
307.12 or commit any nuisances within the limits of a manufactured home park or recreational
307.13 camping area. Each manufactured home park or recreational camping area licensed under
307.14 the provisions of sections 327.10, 327.11, and 327.14 to 327.28 shall, among other things,
307.15 provide for the following~~, in the manner hereinafter specified~~:
307.16 (1) A responsible attendant or caretaker shall be in charge of every manufactured
307.17 home park or recreational camping area at all times, who shall maintain the park or
307.18 area, and its facilities and equipment in a clean, orderly and sanitary condition. In any
307.19 manufactured home park containing more than 50 lots, the attendant, caretaker, or other
307.20 responsible park employee, shall be readily available at all times in case of emergency.
307.21 (2) All manufactured home parks shall be well drained and be located so that the
307.22 drainage of the park area will not endanger any water supply. No wastewater from
307.23 manufactured homes or recreational camping vehicles shall be deposited on the surface of
307.24 the ground. All sewage and other water carried wastes shall be discharged into a municipal
307.25 sewage system whenever available. When a municipal sewage system is not available, a
307.26 sewage disposal system acceptable to the state commissioner of health shall be provided.
307.27 (3) No manufactured home shall be located closer than three feet to the side lot lines
307.28 of a manufactured home park, if the abutting property is improved property, or closer than
307.29 ten feet to a public street or alley. Each individual site shall abut or face on a driveway
307.30 or clear unoccupied space of not less than 16 feet in width, which space shall have
307.31 unobstructed access to a public highway or alley. There shall be an open space of at least
307.32 ten feet between the sides of adjacent manufactured homes including their attachments
307.33 and at least three feet between manufactured homes when parked end to end. The space
307.34 between manufactured homes may be used for the parking of motor vehicles and other
307.35 property, if the vehicle or other property is parked at least ten feet from the nearest

308.1 adjacent manufactured home position. The requirements of this paragraph shall not apply
308.2 to recreational camping areas and variances may be granted by the state commissioner
308.3 of health in manufactured home parks when the variance is applied for in writing and in
308.4 the opinion of the commissioner the variance will not endanger the health, safety, and
308.5 welfare of manufactured home park occupants.

308.6 (4) An adequate supply of water of safe, sanitary quality shall be furnished at each
308.7 manufactured home park or recreational camping area. The source of the water supply
308.8 shall first be approved by the state Department of Health.

308.9 (5) All plumbing shall be installed in accordance with the rules of the state
308.10 commissioner of labor and industry and the provisions of the Minnesota Plumbing Code.

308.11 (6) In the case of a manufactured home park with less than ten manufactured homes,
308.12 a plan for the sheltering or the safe evacuation to a safe place of shelter of the residents of
308.13 the park in times of severe weather conditions, such as tornadoes, high winds, and floods.
308.14 The shelter or evacuation plan shall be developed with the assistance and approval of
308.15 the municipality where the park is located and shall be posted at conspicuous locations
308.16 throughout the park. The park owner shall provide each resident with a copy of the
308.17 approved shelter or evacuation plan, as provided by section 327C.01, subdivision 1c.
308.18 Nothing in this paragraph requires the Department of Health to review or approve any
308.19 shelter or evacuation plan developed by a park. Failure of a municipality to approve a plan
308.20 submitted by a park shall not be grounds for action against the park by the Department of
308.21 Health if the park has made a good faith effort to develop the plan and obtain municipal
308.22 approval.

308.23 (7) A manufactured home park with ten or more manufactured homes, licensed prior
308.24 to March 1, 1988, shall provide a safe place of shelter for park residents or a plan for the
308.25 evacuation of park residents to a safe place of shelter within a reasonable distance of the
308.26 park for use by park residents in times of severe weather, including tornadoes and high
308.27 winds. The shelter or evacuation plan must be approved by the municipality by March 1,
308.28 1989. The municipality may require the park owner to construct a shelter if it determines
308.29 that a safe place of shelter is not available within a reasonable distance from the park. A
308.30 copy of the municipal approval and the plan shall be submitted by the park owner to the
308.31 Department of Health. The park owner shall provide each resident with a copy of the
308.32 approved shelter or evacuation plan, as provided by section 327C.01, subdivision 1c.

308.33 (8) A manufactured home park with ten or more manufactured homes, receiving
308.34 ~~a primary~~ an initial license after March 1, 1988, must provide the type of shelter required
308.35 by section 327.205, except that for manufactured home parks established as temporary,
308.36 emergency housing in a disaster area declared by the President of the United States or

309.1 the governor, an approved evacuation plan may be provided in lieu of a shelter for a
309.2 period not exceeding 18 months.
309.3 (9) For the purposes of this subdivision, "park owner" and "resident" have the
309.4 ~~meaning~~ meanings given them in section 327C.01.

309.5 Sec. 43. Minnesota Statutes 2008, section 327.20, is amended by adding a subdivision
309.6 to read:
309.7 Subd. 4. **Special event recreational camping areas.** Each special event camping
309.8 area licensed under sections 327.10, 327.11, and 327.14 to 327.28 is subject to this section.
309.9 (1) Recreational camping vehicles and tents, including attachments, must be
309.10 separated from each other and other structures by at least seven feet.
309.11 (2) A minimum area of 300 square feet per site must be provided and the total
309.12 number of sites must not exceed one site for every 300 square feet of usable land area.
309.13 (3) Each site must abut or face a driveway or clear unoccupied space of at least 16
309.14 feet in width, which space must have unobstructed access to a public roadway.
309.15 (4) If no approved on-site water supply system is available, hauled water may be
309.16 used, provided that persons using hauled water comply with Minnesota Rules, parts
309.17 4720.4000 to 4720.4600.
309.18 (5) Nonburied sewer lines may be permitted provided they are of approved materials,
309.19 watertight, and properly maintained.
309.20 (6) If a sanitary dumping station is not provided on-site, arrangements must be
309.21 made with a licensed sewage pumper to service recreational camping vehicle holding
309.22 tanks as needed.
309.23 (7) Toilet facilities must be provided consisting of toilets connected to an approved
309.24 sewage disposal system, portable toilets, or approved, properly constructed privies.
309.25 (8) Toilets must be provided in the ratio of one toilet for each sex for each 150 sites.
309.26 (9) Toilets must be not more than 400 feet from any site.
309.27 (10) If a central building or buildings are provided with running water, then toilets
309.28 and handwashing lavatories must be provided in the building or buildings that meet the
309.29 requirements of this subdivision.
309.30 (11) Showers, if provided, must be provided in the ratio of one shower for each sex
309.31 for each 250 sites. Showerheads must be provided, where running water is available, for
309.32 each camping event exceeding two nights.
309.33 (12) Central toilet and shower buildings, if provided, must be constructed with
309.34 adequate heating, ventilation, and lighting, and floors of impervious material sloped

310.1 to drain. Walls must be of a washable material. Permanent facilities must meet the
310.2 requirements of the Americans with Disabilities Act.
310.3 (13) An adequate number of durable, covered, watertight containers must be
310.4 provided for all garbage and refuse. Garbage and refuse must be collected as often as
310.5 necessary to prevent nuisance conditions.
310.6 (14) Campgrounds must be located in areas free of poison ivy or other noxious
310.7 weeds considered detrimental to health. Sites must not be located in areas of tall grass or
310.8 weeds and sites must be adequately drained.
310.9 (15) Campsites for recreational vehicles may not be located on inclines of greater
310.10 than eight percent grade or one inch drop per lineal foot.
310.11 (16) A responsible attendant or caretaker must be available on-site at all times during
310.12 the operation of any special event recreational camping area that has 50 or more sites.

310.13 Sec. 44. **MINNESOTA COLORECTAL CANCER PREVENTION ACT.**
310.14 Subdivision 1. **Purpose.** Colon cancer is one of Minnesota's leading causes of
310.15 death and one of the most preventable forms of cancer. The Minnesota Colorectal
310.16 Cancer Prevention Act creates a demonstration project and public-private partnership
310.17 that leverages business, nonprofit, and government sectors to reduce the incidence of
310.18 colon cancer, reduce future health care expenditures, and address health disparities by
310.19 emphasizing prevention in a manner consistent with Minnesota's health care reform goals.
310.20 Subd. 2. **Establishment.** The commissioner of health shall award grants to
310.21 Hennepin County Medical Center and MeritCare Bemidji for a colorectal screening
310.22 demonstration project to provide screening to uninsured and underinsured women and
310.23 men.
310.24 Subd. 3. **Eligibility.** To be eligible for colorectal screening under this demonstration
310.25 project, an applicant must:
310.26 (1) be at least 50 years of age, or under the age of 50 and at high risk for colon cancer;
310.27 (2) be uninsured, or if insured, has coverage that does not cover the full cost of
310.28 colorectal cancer screenings;
310.29 (3) not eligible for medical assistance, general assistance medical care, or
310.30 MinnesotaCare programs; and
310.31 (4) have a gross family income at or below 250 percent of the federal poverty level.
310.32 Subd. 4. **Services.** Services provided under this project shall include:
310.33 (1) colorectal cancer screening, according to standard practices of medicine, or
310.34 guidelines provided by the Institute for Clinical Systems Improvement or the American
310.35 Cancer Society;

311.1 (2) follow-up services for abnormal tests; and
311.2 (3) diagnostic services to determine the extent and proper course of treatment.
311.3 Subd. 5. **Project evaluation.** The commissioner of health, in consultation with the
311.4 University of Minnesota School of Public Health, shall evaluate the demonstration project
311.5 and make recommendations for increasing the number of persons in Minnesota who
311.6 receive recommended colon cancer screening. The commissioner of health shall submit
311.7 the evaluation and recommendations to the legislature by January 1, 2011.

311.8 Sec. 45. **WOMEN'S HEART HEALTH PILOT PROJECT.**
311.9 Subdivision 1. **Establishment.** The commissioner of health shall develop and
311.10 implement a women's heart health pilot project to provide heart disease risk screening
311.11 to uninsured and underinsured women, who are low-income, American Indian, or other
311.12 minority.
311.13 Subd. 2. **Services.** Under this project, the commissioner must contract with health
311.14 care clinics to provide heart disease risk screenings to eligible women. The clinics may
311.15 also provide follow-up services to women found to be at risk for heart disease.
311.16 Subd. 3. **Eligibility.** To be eligible for screening under this program, an applicant
311.17 must:
311.18 (1) be between the ages of 40 and 64 years;
311.19 (2) receive breast and cervical cancer screening services under the Department of
311.20 Health's Sage program;
311.21 (3) be uninsured, or have insurance that does not cover heart disease risk screenings;
311.22 and
311.23 (4) have a gross family income at or below 150 percent of the federal poverty level.

311.24 Sec. 46. **EXPOSURE LEVELS STUDY.**
311.25 The commissioner of health shall work with appropriate local, state, and federal
311.26 agencies to determine whether the levels of exposure to pentachlorophenol (PCP) in
311.27 Minneapolis neighborhoods where utility poles treated with PCP or creosote, probable
311.28 human carcinogens, are installed, exceed human health risk limits or maximum
311.29 contaminant levels for residents, utility workers, and others who handle the treated poles.

311.30 Sec. 47. **FEASIBILITY PILOT PROJECT FOR CANCER SURVEILLANCE.**
311.31 The commissioner of health must provide a grant to the Hennepin County Medical
311.32 Center for a one-year feasibility pilot project to collect occupational history and residential
311.33 history data from newly diagnosed cancer patients at the Hennepin County Medical

312.1 Center's Cancer Center. Funding for this grant shall come from the Department of Health's
312.2 current resources for the Chronic Disease and Environmental Epidemiology Section.
312.3 Under this pilot project, Hennepin County Medical Center will design an expansion
312.4 of its existing cancer registry to include the collection of additional data, including the
312.5 cancer patient's occupational history, residential history, and military service history.
312.6 Patient consent is required for collection of these additional data. The data collection
312.7 expansion may also include the cancer patient's possible toxic environmental exposure
312.8 history, if known. The purpose of this pilot project is to determine the following:
312.9 (1) the feasibility of collecting these data on a statewide scale;
312.10 (2) the potential design of a self-administered patient questionnaire template; and
312.11 (3) necessary qualifications for staff who will collect these data.
312.12 Hennepin County Medical Center must report the results of this pilot project to the
312.13 legislature by October 1, 2010.

312.14 Sec. 48. **SMOKING CESSATION.**
312.15 The commissioner of health must prioritize smoking prevention and smoking
312.16 cessation activities in low-income, indigenous, and minority communities in their
312.17 collaborations with the ClearWay organization.

312.18 Sec. 49. **MEDICAL RESPONSE UNIT REIMBURSEMENT PILOT PROGRAM.**
312.19 (a) The Department of Public Safety or its contract designee shall collaborate
312.20 with the Minnesota Ambulance Association to create the parameters of the medical
312.21 response unit reimbursement pilot program, including determining criteria for baseline
312.22 data reporting.
312.23 (b) In conducting the pilot program, the Department of Public Safety must consult
312.24 with the Minnesota Ambulance Association, Minnesota Fire Chiefs Association,
312.25 Emergency Services Regulatory Board, and the Minnesota Council of Health Plans to:
312.26 (1) identify no more than five medical response units registered as medical response
312.27 units with the Minnesota Emergency Medical Services Regulatory Board according to
312.28 Minnesota Statutes, chapter 144E, to participate in the program;
312.29 (2) outline and develop criteria for reimbursement;
312.30 (3) determine the amount of reimbursement for each unit response; and
312.31 (4) collect program data to be analyzed for a final report.
312.32 (c) Further criteria for the medical response unit reimbursement pilot program
312.33 shall include:

313.1 (1) the pilot program will expire on December 31, 2010, or when the appropriation
313.2 is extended, whichever occurs first;
313.3 (2) a report shall be made to the legislature by March 1, 2011, by the Department
313.4 of Public Safety or its contractor as to the effectiveness and value of this reimbursement
313.5 pilot program to the emergency medical services delivery system, any actual or potential
313.6 savings to the health care system, and impact on patient outcomes;
313.7 (3) participating medical response units must adhere to the requirements of this
313.8 pilot program outlined in an agreement between the Department of Public Safety and
313.9 the medical response unit, including but not limited to, requirements relating to data
313.10 collection, response criteria, and patient outcomes and disposition;
313.11 (4) individual entities licensed to provide ambulance care under Minnesota Statutes,
313.12 chapter 144E, are not eligible for participation in this pilot program;
313.13 (5) if a participating medical response unit withdraws from the pilot program, the
313.14 Department of Public Safety in consultation with the Minnesota Ambulance Association
313.15 may choose another pilot site if funding is available;
313.16 (6) medical response units must coordinate their operations under this pilot project
313.17 with the ambulance service or services licensed to provide care in their first response
313.18 geographic areas;
313.19 (7) licensed ambulance services that participate with the medical response unit in
313.20 the pilot program assume no financial or legal liability for the actions of the participating
313.21 medical response unit; and
313.22 (8) the Department of Public Safety and its pilot program partners have no ongoing
313.23 responsibility to reimburse medical response units beyond the parameters of the pilot
313.24 program.

313.25 Sec. 50. **REPEALER.**
313.26 (a) Minnesota Statutes 2008, sections 103I.112; 144.9501, subdivision 17b; and
313.27 327.14, subdivisions 5 and 6, are repealed.
313.28 (b) Minnesota Rules, part 4626.2015, subpart 9, is repealed.

313.29 **ARTICLE 12**
313.30 **HEALTH-RELATED FEES**

313.31 Section 1. Minnesota Statutes 2008, section 148.108, is amended to read:
313.32 **148.108 FEES.**

Subdivision 1. **Fees.** In addition to the fees established in Minnesota Rules, chapter 2500, and according to sections 148.05, 148.06, 148.07, and 148.10, subdivisions 2 and 3, the board is authorized to charge the fees in this section.

Subd. 2. ~~**Annual renewal of inactive acupuncture registration**~~ **License and registration fees.** ~~The annual renewal of an inactive acupuncture registration fee is $25.~~ License and registration fees are as follows:

(1) for a license application fee, $300;

(2) for a license active renewal fee, $220;

(3) for a license inactive renewal fee, $165;

(4) for an acupuncture initial registration fee, $125;

(5) for an acupuncture active registration renewal fee, $75;

(6) for an acupuncture registration reinstatement fee, $50;

(7) for an acupuncture inactive registration renewal fee, $25;

(8) for an animal chiropractic registration fee, $125;

(9) for an animal chiropractic active registration renewal fee, $75; and

(10) for an animal chiropractic inactive registration renewal fee, $25.

~~Subd. 3. **Acupuncture reinstatement.** The acupuncture reinstatement fee is $50.~~

Sec. 2. Minnesota Statutes 2008, section 148D.180, subdivision 1, is amended to read:

Subdivision 1. **Application fees.** Application fees for licensure are as follows:

(1) for a licensed social worker, $45;

(2) for a licensed graduate social worker, $45;

(3) for a licensed independent social worker, ~~$90~~ $45;

(4) for a licensed independent clinical social worker, ~~$90~~ $45;

(5) for a temporary license, $50; and

(6) for a licensure by endorsement, ~~$150~~ $85.

The fee for criminal background checks is the fee charged by the Bureau of Criminal Apprehension. The criminal background check fee must be included with the application fee as required pursuant to section 148D.055.

Sec. 3. Minnesota Statutes 2008, section 148D.180, subdivision 2, is amended to read:

Subd. 2. **License fees.** License fees are as follows:

(1) for a licensed social worker, ~~$115.20~~ $81;

(2) for a licensed graduate social worker, ~~$201.60~~ $144;

(3) for a licensed independent social worker, ~~$302.40~~ $216;

(4) for a licensed independent clinical social worker, ~~$331.20~~ $238.50;

315.1 (5) for an emeritus license, $43.20; and

315.2 (6) for a temporary leave fee, the same as the renewal fee specified in subdivision 3.

315.3 If the licensee's initial license term is less or more than 24 months, the required

315.4 license fees must be prorated proportionately.

315.5 Sec. 4. Minnesota Statutes 2008, section 148D.180, subdivision 3, is amended to read:

315.6 Subd. 3. **Renewal fees.** Renewal fees for licensure are as follows:

315.7 (1) for a licensed social worker, ~~$115.20~~ $81;

315.8 (2) for a licensed graduate social worker, ~~$201.60~~ $144;

315.9 (3) for a licensed independent social worker, ~~$302.40~~ $216; and

315.10 (4) for a licensed independent clinical social worker, ~~$331.20~~ $238.50.

315.11 Sec. 5. Minnesota Statutes 2008, section 148D.180, subdivision 5, is amended to read:

315.12 Subd. 5. **Late fees.** Late fees are as follows:

315.13 (1) renewal late fee, ~~one-half~~ one-fourth of the renewal fee specified in subdivision

315.14 3; and

315.15 (2) supervision plan late fee, $40.

315.16 Sec. 6. Minnesota Statutes 2008, section 148E.180, subdivision 1, is amended to read:

315.17 Subdivision 1. **Application fees.** Application fees for licensure are as follows:

315.18 (1) for a licensed social worker, $45;

315.19 (2) for a licensed graduate social worker, $45;

315.20 (3) for a licensed independent social worker, ~~$90~~ $45;

315.21 (4) for a licensed independent clinical social worker, ~~$90~~ $45;

315.22 (5) for a temporary license, $50; and

315.23 (6) for a licensure by endorsement, ~~$150~~ $85.

315.24 The fee for criminal background checks is the fee charged by the Bureau of Criminal

315.25 Apprehension. The criminal background check fee must be included with the application

315.26 fee as required according to section 148E.055.

315.27 Sec. 7. Minnesota Statutes 2008, section 148E.180, subdivision 2, is amended to read:

315.28 Subd. 2. **License fees.** License fees are as follows:

315.29 (1) for a licensed social worker, ~~$115.20~~ $81;

315.30 (2) for a licensed graduate social worker, ~~$201.60~~ $144;

315.31 (3) for a licensed independent social worker, ~~$302.40~~ $216;

315.32 (4) for a licensed independent clinical social worker, ~~$331.20~~ $238.50;

316.1 (5) for an emeritus license, $43.20; and

316.2 (6) for a temporary leave fee, the same as the renewal fee specified in subdivision 3.

316.3 If the licensee's initial license term is less or more than 24 months, the required
316.4 license fees must be prorated proportionately.

316.5 Sec. 8. Minnesota Statutes 2008, section 148E.180, subdivision 3, is amended to read:

316.6 Subd. 3. **Renewal fees.** Renewal fees for licensure are as follows:

316.7 (1) for a licensed social worker, ~~$115.20~~ $81;

316.8 (2) for a licensed graduate social worker, ~~$201.60~~ $144;

316.9 (3) for a licensed independent social worker, ~~$302.40~~ $216; and

316.10 (4) for a licensed independent clinical social worker, ~~$331.20~~ $238.50.

316.11 Sec. 9. Minnesota Statutes 2008, section 148E.180, subdivision 5, is amended to read:

316.12 Subd. 5. **Late fees.** Late fees are as follows:

316.13 (1) renewal late fee, ~~one-half~~ one-fourth of the renewal fee specified in subdivision
316.14 3; and

316.15 (2) supervision plan late fee, $40.

316.16 Sec. 10. **[156.011] LICENSE, APPLICATION, AND EXAMINATION FEES.**

316.17 Subdivision 1. **Application fee.** A person applying for a license to practice
316.18 veterinary medicine in Minnesota or applying for a permit to take the national veterinary
316.19 medical examination must pay a $60 nonrefundable application fee to the board. Persons
316.20 submitting concurrent applications for licensure and a national examination permit shall
316.21 pay only one application fee.

316.22 Subd. 2. **Examination fees.** (a) An applicant for veterinary licensure in Minnesota
316.23 must successfully pass the Minnesota Veterinary Jurisprudence Examination. The fee for
316.24 this examination is $60, payable to the board.

316.25 (b) An applicant participating in the national veterinary licensing examination must
316.26 complete a separate application for the national examination and submit the application
316.27 to the board for approval. Payment for the national examination must be made by the
316.28 applicant to the national board examination committee.

316.29 Sec. 11. **[156.012] INITIAL AND RENEWAL FEE.**

316.30 Subdivision 1. **Required for licensure.** A person now licensed to practice
316.31 veterinary medicine in this state, or who becomes licensed by the Board of Veterinary
316.32 Medicine to engage in the practice, shall pay an initial fee or a biennial license renewal

317.1 fee if the person wishes to practice veterinary medicine in the coming two-year period
317.2 or remain licensed as a veterinarian. A licensure period begins on March 1 and expires
317.3 the last day of February two years later. A licensee with an even-numbered license shall
317.4 renew by March 1 of even-numbered years and a licensee with an odd-numbered license
317.5 shall renew by March 1 of odd-numbered years.

317.6 Subd. 2. **Amount.** The initial licensure fee and the biennial renewal fee is $280
317.7 and must be paid to the executive director of the board. By January 1 of the first year
317.8 for which the biennial renewal fee is due, the board shall issue a renewal application to
317.9 a current licensee to the last address maintained in the board file. Failure to receive this
317.10 notice does not relieve the licensee of the obligation to pay renewal fees so that they are
317.11 received by the board on or before the renewal date of March 1.

317.12 Initial licenses issued after the start of the licensure renewal period are valid only
317.13 until the end of the period.

317.14 Subd. 3. **Date due.** A licensee must apply for a renewal license on or before March
317.15 1 of the first year of the biennial license renewal period. A renewal license is valid
317.16 from March 1 through the last day of February of the last year of the two-year license
317.17 renewal period. An application postmarked no later than the last day of February must be
317.18 considered to have been received on March 1.

317.19 Subd. 4. **Late renewal penalty.** An applicant for renewal must pay a late renewal
317.20 penalty of $140 in addition to the renewal fee if the application for renewal is received
317.21 after March 1 of the licensure renewal period. A renewed license issued after March 1 of
317.22 the licensure renewal period is valid only to the end of the period regardless of when the
317.23 renewal fee is received.

317.24 Subd. 5. **Reinstatement fee.** An applicant for license renewal whose license
317.25 has previously been suspended by official board action for nonrenewal must pay a
317.26 reinstatement fee of $60 in addition to the $280 renewal fee and the $140 late renewal
317.27 penalty.

317.28 Subd. 6. **Penalty for failure to pay.** Within 30 days after the renewal date, a
317.29 licensee who has not renewed the license must be notified by letter sent to the last known
317.30 address of the licensee in the file of the board that the renewal is overdue and that failure
317.31 to pay the current fee and current late fee within 60 days after the renewal date will result
317.32 in suspension of the license. A second notice must be sent by registered or certified mail at
317.33 least seven days before a board meeting occurring 60 days or more after the renewal date
317.34 to a licensee who has not paid the renewal fee and late fee.

317.35 Subd. 7. **Suspension.** The board, by means of a roll call vote, shall suspend the
317.36 license of a licensee whose license renewal is at least 60 days overdue and to whom

318.1 notification has been sent as provided in Minnesota Rules, part 9100.0500, subpart 5.
318.2 Failure of a licensee to receive notification is not grounds for later challenge by the
318.3 licensee of the suspension. The former licensee must be notified by registered or certified
318.4 letter within seven days of the board action. The suspended status placed on a license may
318.5 be removed only on payment of renewal fees and late penalty fees for each licensure
318.6 period or part of a period that the license was not renewed. A licensee who fails to renew a
318.7 license for five years or more must meet the criteria of section 156.071 for relicensure.

318.8 Subd. 8. **Inactive license.** (a) A person holding a current active license to practice
318.9 veterinary medicine in Minnesota may, at the time of the person's next biennial license
318.10 renewal date, renew the license as an inactive license at one-half the renewal fee of an
318.11 active license. The license may be continued in an inactive status by renewal on a biennial
318.12 basis at one-half the regular license fee.

318.13 (b) A person holding an inactive license is not permitted to practice veterinary
318.14 medicine in Minnesota and remains under the disciplinary authority of the board.

318.15 (c) A person may convert a current inactive license to an active license upon
318.16 application to and approval by the board. The application must include:

318.17 (1) documentation of licensure in good standing and of having met continuing
318.18 education requirements of current state of practice, or documentation of having met
318.19 Minnesota continuing education requirements retroactive to the date of licensure
318.20 inactivation;

318.21 (2) certification by the applicant that the applicant is not currently under disciplinary
318.22 orders or investigation for acts that could result in disciplinary action in any other
318.23 jurisdiction; and

318.24 (3) payment of a fee equal to the full difference between an inactive and active
318.25 license if converting during the first year of the biennial license cycle or payment of a fee
318.26 equal to one-half the difference between an inactive and an active license if converting
318.27 during the second year of the license cycle.

318.28 (d) Deadline for renewal of an inactive license is March 1 of the first year of the
318.29 biennial license renewal period. A late renewal penalty of one-half the inactive renewal
318.30 fee must be paid if renewal is received after March 1.

318.31 Sec. 12. Minnesota Statutes 2008, section 156.015, is amended to read:

318.32 **156.015 MISCELLANEOUS FEES.**

318.33 Subdivision 1. **Verification of licensure.** The board may charge a fee of $25 per
318.34 license verification to a licensee for verification of licensure status provided to other
318.35 veterinary licensing boards.

319.1 Subd. 2. **Continuing education review.** The board may charge a fee of $50 per
319.2 submission to a sponsor for review and approval of individual continuing education
319.3 seminars, courses, wet labs, and lectures. This fee does not apply to continuing education
319.4 sponsors that already meet the criteria for preapproval under Minnesota Rules, part
319.5 9100.1000, subpart 3, item A.

319.6 Subd. 3. **Temporary license fee.** A person meeting the requirements for issuance
319.7 of a temporary permit to practice veterinary medicine under section 156.073, pending
319.8 examination, who desires a temporary permit shall pay a fee of $60 to the board.

319.9 Subd. 4. **Duplicate license.** A person requesting issuance of a duplicate or
319.10 replacement license shall pay a fee of $15 to the board.

319.11 Subd. 5. **Mailing examination and reference materials.** An applicant who resides
319.12 outside the Twin Cities metropolitan area may request to take the Minnesota Veterinary
319.13 Jurisprudence Examination by mail. The fee for mailing the examination and reference
319.14 materials is $15.

319.15 Sec. 13. **REPEALER.**

319.16 (a) Minnesota Rules, parts 9100.0400, subparts 1 and 3; 9100.0500; and 9100.0600,
319.17 are repealed.

319.18 (b) Minnesota Statutes 2008, section 148D.180, subdivision 8, is repealed.

319.19 **ARTICLE 13**

319.20 **MISCELLANEOUS**

319.21 Section 1. Minnesota Statutes 2008, section 256.045, subdivision 3, is amended to read:

319.22 Subd. 3. **State agency hearings.** (a) State agency hearings are available for the
319.23 following:

319.24 (1) any person applying for, receiving or having received public assistance, medical
319.25 care, or a program of social services granted by the state agency or a county agency or
319.26 the federal Food Stamp Act whose application for assistance is denied, not acted upon
319.27 with reasonable promptness, or whose assistance is suspended, reduced, terminated, or
319.28 claimed to have been incorrectly paid;

319.29 (2) any patient or relative aggrieved by an order of the commissioner under section
319.30 252.27;

319.31 (3) a party aggrieved by a ruling of a prepaid health plan;

319.32 (4) except as provided under chapter 245C, any individual or facility determined by
319.33 a lead agency to have maltreated a vulnerable adult under section 626.557 after they have
319.34 exercised their right to administrative reconsideration under section 626.557;

320.1 (5) any person whose claim for foster care payment according to a placement of the
320.2 child resulting from a child protection assessment under section 626.556 is denied or not
320.3 acted upon with reasonable promptness, regardless of funding source;
320.4 (6) any person to whom a right of appeal according to this section is given by other
320.5 provision of law;
320.6 (7) an applicant aggrieved by an adverse decision to an application for a hardship
320.7 waiver under section 256B.15;
320.8 (8) an applicant aggrieved by an adverse decision to an application or redetermination
320.9 for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a;
320.10 (9) except as provided under chapter 245A, an individual or facility determined
320.11 to have maltreated a minor under section 626.556, after the individual or facility has
320.12 exercised the right to administrative reconsideration under section 626.556; ~~or~~
320.13 (10) except as provided under chapter 245C, an individual disqualified under sections
320.14 245C.14 and 245C.15, on the basis of serious or recurring maltreatment; a preponderance
320.15 of the evidence that the individual has committed an act or acts that meet the definition
320.16 of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make
320.17 reports required under section 626.556, subdivision 3, or 626.557, subdivision 3. Hearings
320.18 regarding a maltreatment determination under clause (4) or (9) and a disqualification under
320.19 this clause in which the basis for a disqualification is serious or recurring maltreatment,
320.20 which has not been set aside under sections 245C.22 and 245C.23, shall be consolidated
320.21 into a single fair hearing. In such cases, the scope of review by the human services referee
320.22 shall include both the maltreatment determination and the disqualification. The failure to
320.23 exercise the right to an administrative reconsideration shall not be a bar to a hearing under
320.24 this section if federal law provides an individual the right to a hearing to dispute a finding
320.25 of maltreatment. Individuals and organizations specified in this section may contest the
320.26 specified action, decision, or final disposition before the state agency by submitting a
320.27 written request for a hearing to the state agency within 30 days after receiving written
320.28 notice of the action, decision, or final disposition, or within 90 days of such written notice
320.29 if the applicant, recipient, patient, or relative shows good cause why the request was not
320.30 submitted within the 30-day time limit~~.~~; or
320.31 (11) any person with an outstanding debt resulting from receipt of public assistance,
320.32 medical care, or the federal Food Stamp Act who is contesting a setoff claim by the
320.33 Department of Human Services or a county agency. The scope of the appeal is the validity
320.34 of the claimant agency's intention to request a setoff of a refund under chapter 270A
320.35 against the debt.

321.1 (b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or
321.2 (10), is the only administrative appeal to the final agency determination specifically,
321.3 including a challenge to the accuracy and completeness of data under section 13.04.
321.4 Hearings requested under paragraph (a), clause (4), apply only to incidents of maltreatment
321.5 that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing
321.6 homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a
321.7 contested case proceeding under the provisions of chapter 14. Hearings requested under
321.8 paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after
321.9 July 1, 1997. A hearing for an individual or facility under paragraph (a), clause (9), is
321.10 only available when there is no juvenile court or adult criminal action pending. If such
321.11 action is filed in either court while an administrative review is pending, the administrative
321.12 review must be suspended until the judicial actions are completed. If the juvenile court
321.13 action or criminal charge is dismissed or the criminal action overturned, the matter may be
321.14 considered in an administrative hearing.

321.15 (c) For purposes of this section, bargaining unit grievance procedures are not an
321.16 administrative appeal.

321.17 (d) The scope of hearings involving claims to foster care payments under paragraph
321.18 (a), clause (5), shall be limited to the issue of whether the county is legally responsible
321.19 for a child's placement under court order or voluntary placement agreement and, if so,
321.20 the correct amount of foster care payment to be made on the child's behalf and shall not
321.21 include review of the propriety of the county's child protection determination or child
321.22 placement decision.

321.23 (e) A vendor of medical care as defined in section 256B.02, subdivision 7, or a
321.24 vendor under contract with a county agency to provide social services is not a party and
321.25 may not request a hearing under this section, except if assisting a recipient as provided in
321.26 subdivision 4.

321.27 (f) An applicant or recipient is not entitled to receive social services beyond the
321.28 services prescribed under chapter 256M or other social services the person is eligible
321.29 for under state law.

321.30 (g) The commissioner may summarily affirm the county or state agency's proposed
321.31 action without a hearing when the sole issue is an automatic change due to a change in
321.32 state or federal law.

321.33 Sec. 2. Minnesota Statutes 2008, section 256.983, subdivision 1, is amended to read:

321.34 Subdivision 1. **Programs established.** Within the limits of available appropriations,
321.35 the commissioner of human services shall require the maintenance of budget neutral

322.1 fraud prevention investigation programs in the counties participating in the fraud
322.2 prevention investigation project established under this section. If funds are sufficient,
322.3 the commissioner may also extend fraud prevention investigation programs to other
322.4 counties provided the expansion is budget neutral to the state. Under any expansion, the
322.5 commissioner has the final authority in decisions regarding the creation and realignment
322.6 of individual count or regional operations.

322.7 Sec. 3. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision
322.8 to read:

322.9 Subd. 3b. **Extension; adoption finalized after age 16.** A child who has attained the
322.10 age of 16 prior to finalization of their adoption is eligible for extension of the adoption
322.11 assistance agreement to the date the child attains age 21 if the child is:

322.12 (1) completing a secondary education program or a program leading to an equivalent
322.13 credential;

322.14 (2) enrolled in an institution which provides postsecondary or vocational education;

322.15 (3) participating in a program or activity designed to promote or remove barriers to
322.16 employment;

322.17 (4) employed for at least 80 hours per month; or

322.18 (5) incapable of doing any of the activities described in clauses (1) to (4) due to a
322.19 medical condition which incapability is supported by regularly updated information in
322.20 the case plan of the child.

322.21 **EFFECTIVE DATE.** This section is effective October 1, 2010.

322.22 Sec. 4. Minnesota Statutes 2008, section 270A.09, is amended by adding a subdivision
322.23 to read:

322.24 Subd. 1b. **Department of Human Services claims.** Notwithstanding subdivision 1,
322.25 any debtor contesting a setoff claim by the Department of Human Services or a county
322.26 agency whose claim relates to a debt resulting from receipt of public assistance, medical
322.27 care, or the federal Food Stamp Act shall have a hearing conducted in the same manner as
322.28 an appeal under sections 256.045 and 256.0451.

322.29 ARTICLE 14
322.30 HUMAN SERVICES FORECAST ADJUSTMENTS

322.31 Section 1. **SUMMARY OF APPROPRIATIONS; DEPARTMENT OF HUMAN**
322.32 **SERVICES FORECAST ADJUSTMENT.**

323.1 The dollar amounts shown are added to or, if shown in parentheses, are subtracted
323.2 from the appropriations in Laws 2008, chapter 363, from the general fund, or any other
323.3 fund named, to the Department of Human Services for the purposes specified in this article,
323.4 to be available for the fiscal year indicated for each purpose. The figure "2009" used in
323.5 this article means that the appropriation or appropriations listed are available for the fiscal
323.6 year ending June 30, 2009. Supplemental appropriations and reductions to appropriations
323.7 for the fiscal year ending June 30, 2009, are effective the day following final enactment.

323.8 Sec. 2. **COMMISSIONER OF HUMAN**
323.9 **SERVICES**

323.10	Subdivision 1. **Total Appropriation**		**$ (478,994,000)**
323.11	Appropriations by Fund		
323.12		2009	
323.13	General	(445,130,000)	
323.14	Health Care Access	(19,460,000)	
323.15	Federal TANF	(14,404,000)	
323.16	Subd. 2. **Revenue and Pass-Through**		
323.17	Federal TANF	1,107,000	
323.18–323.19	Subd. 3. **Children and Economic Assistance Grants**		
323.20	General	27,002,000	
323.21	Federal TANF	(16,211,000)	
323.22	Total	10,791,000	

323.23 The amounts that may be spent from this
323.24 appropriation for each purpose are as follows:

323.25 (a) **MFIP/DWP Grants**

323.26	General	17,530,000	
323.27	Federal TANF	(16,211,000)	
323.28	(b) **MFIP Child Care Assistance Grants**		4,933,000
323.29	(c) **General Assistance Grants**		1,458,000
323.30	(d) **Minnesota Supplemental Aid Grants**		513,000
323.31	(e) **Group Residential Housing Grants**		2,568,000

323.32 Subd. 4. **Basic Health Care Grants**

General	(224,341,000)
Health Care Access	(19,460,000)
Total	(243,801,000)

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) **MinnesotaCare**

Health Care Access	(19,460,000)	
(b) **MA Basic Health Care - Families and Children**		(100,055,000)
(c) **MA Basic Health Care - Elderly and Disabled**		(136,795,000)
(d) **General Assistance Medical Care**		12,539,000
Subd. 5. **Continuing Care Grants**		**(247,791,000)**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) **MA Long-Term Care Facilities**	(59,204,000)
(b) **MA Long-Term Care Waivers**	(168,927,000)
(c) **Chemical Dependency Entitlement Grants**	(19,660,000)

ARTICLE 15
APPROPRIATIONS

Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations by fund made in this article.

	2010	**2011**	**Total**
General	$ 4,362,970,000	$ 5,223,144,000	$ 9,586,114,000
State Government Special Revenue	63,219,000	63,139,000	126,358,000
Health Care Access	484,881,000	575,920,000	1,060,801,000
Federal TANF	288,605,000	256,149,000	544,754,000
Lottery Prize	1,665,000	1,665,000	3,330,000
Federal Fund	104,300,000	0	104,300,000
Total	**$ 5,305,640,000**	**$ 6,120,010,000**	**$ 11,425,657,000**

Sec. 2. **HEALTH AND HUMAN SERVICES APPROPRIATION.**

325.1 The sums shown in the columns marked "Appropriations" are appropriated to the
325.2 agencies and for the purposes specified in this article. The appropriations are from the
325.3 general fund, or another named fund, and are available for the fiscal years indicated
325.4 for each purpose. The figures "2010" and "2011" used in this article mean that the
325.5 appropriations listed under them are available for the fiscal year ending June 30, 2010, or
325.6 June 30, 2011, respectively. "The first year" is fiscal year 2010. "The second year" is fiscal
325.7 year 2011. "The biennium" is fiscal years 2010 and 2011. Appropriations from the federal
325.8 fund are from money received under the American Reinvestment and Recovery Act of
325.9 2009, Public Law 111-5, unless otherwise specified. Appropriations for the fiscal year
325.10 ending June 30, 2009, are effective the day following final enactment.

	APPROPRIATIONS Available for the Year Ending June 30	
	2010	**2011**

325.11–325.14

325.15 Sec. 3. **HUMAN SERVICES**

325.16 Subdivision 1. **Total Appropriation** **$ 5,157,375,000** **$ 5,954,708,000**

325.17 Appropriations by Fund

	2010	2011
General	4,282,964,000	5,153,316,000
State Government Special Revenue	1,315,000	565,000
Health Care Access	478,526,000	569,113,000
Federal TANF	288,605,000	230,049,000
Lottery Prize	1,665,000	1,665,000
Federal Fund	104,300,000	0

325.26 **Receipts for Systems Projects.**
325.27 Appropriations and federal receipts for
325.28 information systems projects for MAXIS,
325.29 PRISM, MMIS, and SSIS must be deposited
325.30 in the state system account authorized in
325.31 Minnesota Statutes, section 256.014. Money
325.32 appropriated for computer projects approved
325.33 by the Minnesota Office of Enterprise
325.34 Technology, funded by the legislature, and
325.35 approved by the commissioner of finance,
325.36 may be transferred from one project to
325.37 another and from development to operations

326.1 as the commissioner of human services
326.2 considers necessary. Any unexpended
326.3 balance in the appropriation for these
326.4 projects does not cancel but is available for
326.5 ongoing development and operations.

326.6 **Nonfederal Share Transfers.** The
326.7 nonfederal share of activities for which
326.8 federal administrative reimbursement is
326.9 appropriated to the commissioner may be
326.10 transferred to the special revenue fund.

326.11 **TANF Maintenance of Effort.**

326.12 (a) In order to meet the basic maintenance
326.13 of effort (MOE) requirements of the TANF
326.14 block grant specified under Code of Federal
326.15 Regulations, title 45, section 263.1, the
326.16 commissioner may only report nonfederal
326.17 money expended for allowable activities
326.18 listed in the following clauses as TANF/MOE
326.19 expenditures:

326.20 (1) MFIP cash, diversionary work program,
326.21 and food assistance benefits under Minnesota
326.22 Statutes, chapter 256J;

326.23 (2) the child care assistance programs
326.24 under Minnesota Statutes, sections 119B.03
326.25 and 119B.05, and county child care
326.26 administrative costs under Minnesota
326.27 Statutes, section 119B.15;

326.28 (3) state and county MFIP administrative
326.29 costs under Minnesota Statutes, chapters
326.30 256J and 256K;

326.31 (4) state, county, and tribal MFIP
326.32 employment services under Minnesota
326.33 Statutes, chapters 256J and 256K;

327.1 (5) expenditures made on behalf of
327.2 noncitizen MFIP recipients who qualify
327.3 for the medical assistance without federal
327.4 financial participation program under
327.5 Minnesota Statutes, section 256B.06,
327.6 subdivision 4, paragraphs (d), (e), and (j);
327.7 and

327.8 (6) qualifying working family credit
327.9 expenditures under Minnesota Statutes,
327.10 section 290.0671.

327.11 (b) The commissioner shall ensure that
327.12 sufficient qualified nonfederal expenditures
327.13 are made each year to meet the state's
327.14 TANF/MOE requirements. For the activities
327.15 listed in paragraph (a), clauses (2) to
327.16 (6), the commissioner may only report
327.17 expenditures that are excluded from the
327.18 definition of assistance under Code of
327.19 Federal Regulations, title 45, section 260.31.

327.20 (c) For fiscal years beginning with state
327.21 fiscal year 2003, the commissioner shall
327.22 ensure that the maintenance of effort used
327.23 by the commissioner of finance for the
327.24 February and November forecasts required
327.25 under Minnesota Statutes, section 16A.103,
327.26 contains expenditures under paragraph (a),
327.27 clause (1), equal to at least 16 percent of
327.28 the total required under Code of Federal
327.29 Regulations, title 45, section 263.1.

327.30 (d) For the federal fiscal years beginning on
327.31 or after October 1, 2007, the commissioner
327.32 may not claim an amount of TANF/MOE in
327.33 excess of the 75 percent standard in Code
327.34 of Federal Regulations, title 45, section
327.35 263.1(a)(2), except:

328.1 (1) to the extent necessary to meet the 80
328.2 percent standard under Code of Federal
328.3 Regulations, title 45, section 263.1(a)(1),
328.4 if it is determined by the commissioner
328.5 that the state will not meet the TANF work
328.6 participation target rate for the current year;

328.7 (2) to provide any additional amounts
328.8 under Code of Federal Regulations, title 45,
328.9 section 264.5, that relate to replacement of
328.10 TANF funds due to the operation of TANF
328.11 penalties; and

328.12 (3) to provide any additional amounts that
328.13 may contribute to avoiding or reducing
328.14 TANF work participation penalties through
328.15 the operation of the excess MOE provisions
328.16 of Code of Federal Regulations, title 45,
328.17 section 261.43(a)(2).

328.18 For the purposes of clauses (1) to (3),
328.19 the commissioner may supplement the
328.20 MOE claim with working family credit
328.21 expenditures to the extent such expenditures
328.22 or other qualified expenditures are otherwise
328.23 available after considering the expenditures
328.24 allowed in this section.

328.25 (e) Minnesota Statutes, section 256.011,
328.26 subdivision 3, which requires that federal
328.27 grants or aids secured or obtained under that
328.28 subdivision be used to reduce any direct
328.29 appropriations provided by law, do not apply
328.30 if the grants or aids are federal TANF funds.

328.31 (f) Notwithstanding any contrary provision
328.32 in this article, this provision expires June 30,
328.33 2013.

328.34 **Working Family Credit Expenditures as**
328.35 **TANF/MOE.** The commissioner may claim

329.1 as TANF/MOE up to $6,707,000 per year for
329.2 fiscal year 2010 through fiscal year 2011.

329.3 **Working Family Credit Expenditures**
329.4 **to be Claimed for TANF/MOE.** The
329.5 commissioner may count the following
329.6 amounts of working family credit expenditure
329.7 as TANF/MOE:

329.8 (1) fiscal year 2010, $23,688,000;

329.9 (2) fiscal year 2011, $42,002,000;

329.10 (3) fiscal year 2012, $48,701,000; and

329.11 (4) fiscal year 2013, $49,359,000.

329.12 Notwithstanding any contrary provision in
329.13 this article, this rider expires June 30, 2013.

329.14 **TANF Transfer to Federal Child Care**
329.15 **and Development Fund.** The following
329.16 TANF fund amounts are appropriated to the
329.17 commissioner for the purposes of MFIP and
329.18 transition year child care under Minnesota
329.19 Statutes, section 119B.05:

329.20 (1) fiscal year 2010, $0;

329.21 (2) fiscal year 2011, $8,959,000;

329.22 (3) fiscal year 2012, $35,129,000; and

329.23 (4) fiscal year 2013, $35,848,000.

329.24 The commissioner shall authorize the
329.25 transfer of sufficient TANF funds to the
329.26 federal child care and development fund to
329.27 meet this appropriation and shall ensure that
329.28 all transferred funds are expended according
329.29 to federal child care and development fund
329.30 regulations. The transferred funds shall be
329.31 used to offset any general fund reductions to
329.32 MFIP child care in this article.

330.1 **Emergency Fund for the TANF Program.**
330.2 TANF Emergency Contingency funds
330.3 available under the American Recovery
330.4 and Reinvestment Act of 2009 (Public Law
330.5 111-5) are appropriated to the commissioner.
330.6 The commissioner must request TANF
330.7 Emergency Contingency funds from the
330.8 Secretary of the Department of Health
330.9 and Human Services to the extent the
330.10 commissioner meets or expects to meet the
330.11 requirements of section 403(c) of the Social
330.12 Security Act. The commissioner must seek
330.13 to maximize such grants. The funds received
330.14 must be used as appropriated.

330.15 Subd. 2. **Agency Management**

330.16 The amounts that may be spent from the
330.17 appropriation for each purpose are as follows:

330.18 **(a) Financial Operations**

330.19	Appropriations by Fund		
330.20	General	3,380,000	3,908,000
330.21	Health Care Access	1,241,000	1,016,000
330.22	Federal TANF	122,000	122,000

330.23 **(b) Legal and Regulatory Operations**

330.24	Appropriations by Fund		
330.25	General	13,710,000	13,495,000
330.26 330.27	State Government Special Revenue	440,000	440,000
330.28	Health Care Access	943,000	943,000
330.29	Federal TANF	100,000	100,000

330.30 **Base Adjustment.** The general fund base
330.31 is decreased $4,550,000 in fiscal year 2012
330.32 and $4,550,000 in fiscal year 2013. The state
330.33 government special revenue fund base is
330.34 increased $4,500,000 in fiscal year 2012 and
330.35 $4,500,000 in fiscal year 2013.

331.1 **(c) Management Operations**

331.2	Appropriations by Fund		
331.3 General		4,715,000	4,715,000
331.4 Health Care Access		242,000	242,000

331.5 **(d) Information Technology Operations**

331.6	Appropriations by Fund		
331.7 General		28,077,000	28,077,000
331.8 Health Care Access		4,856,000	4,868,000

331.9 Subd. 3. **Revenue and Pass-Through Revenue** 331.10 **Expenditures**	65,746,000	76,027,000

331.11 This appropriation is from the federal TANF
331.12 fund.

331.13 Subd. 4. **Children and Economic Assistance**
331.14 **Grants**

331.15 The amounts that may be spent from this
331.16 appropriation for each purpose are as follows:

331.17 **(a) MFIP/DWP Grants**

331.18	Appropriations by Fund		
331.19 General		68,634,000	98,587,000
331.20 Federal TANF		96,357,000	68,320,000

331.21 **(b) Support Services Grants**

331.22	Appropriations by Fund		
331.23 General		8,715,000	8,715,000
331.24 Federal TANF		113,711,000	99,111,000

331.25 **MFIP Consolidated Fund.** The MFIP
331.26 consolidated fund TANF appropriation is
331.27 reduced by $5,500,000 in fiscal year 2011.

331.28 **Integrated Services Program Funding.**
331.29 The TANF appropriation for integrated
331.30 services program funding is $1,250,000 in
331.31 fiscal year 2010 and $0 in fiscal year 2011.

331.32 **TANF Emergency Fund; Nonrecurrent**
331.33 **Short-Term Benefits.** TANF Emergency
331.34 Contingency fund grants received due to

332.1 increases in expenditures for nonrecurrent
332.2 short-term benefits must be used to offset the
332.3 increase in these expenditures for counties
332.4 under the MFIP consolidated fund under
332.5 Minnesota Statutes, section 256J.626,
332.6 and the diversionary work program. The
332.7 commissioner shall develop procedures
332.8 to maximize reimbursement of these
332.9 expenditures over the TANF emergency fund
332.10 base year quarters.

332.11 **(c) MFIP Child Care Assistance Grants**	(18,000)	(9,254,000)
332.12 **(d) Child Care Development Grants**	4,000	4,000
332.13 **(e) Child Support Enforcement Grants**	3,705,000	3,705,000

332.14 **(f) Children's Services Grants**

332.15	Appropriations by Fund	
332.16 General	47,533,000	50,498,000
332.17 Federal TANF	340,000	240,000

332.18 **Base Adjustment.** The general fund base is
332.19 increased by $3,094,000 in fiscal year 2012
332.20 and $18,907,000 in fiscal year 2013.

332.21 **Privatized Adoption Grants.** Federal
332.22 reimbursement for privatized adoption grant
332.23 and foster care recruitment grant expenditures
332.24 is appropriated to the commissioner for
332.25 adoption grants and foster care and adoption
332.26 administrative purposes.

332.27 **Adoption Assistance Incentive Grants.**
332.28 Federal funds available during fiscal year
332.29 2010 and fiscal year 2011 for the adoption
332.30 incentive grants are appropriated to the
332.31 commissioner for these purposes.

332.32 **Adoption Assistance and Relative Custody**
332.33 **Assistance.** The commissioner may transfer
332.34 unencumbered appropriation balances for

333.1 adoption assistance and relative custody
333.2 assistance between fiscal years and between
333.3 programs.

333.4 **(g) Children and Community Services Grants**	67,604,000	67,463,000

333.5 **Targeted Case Management Temporary**
333.6 **Funding Adjustment.** The commissioner
333.7 shall recover from each county and tribe
333.8 receiving a targeted case management
333.9 temporary funding payment in fiscal year
333.10 2008 an amount equal to that payment. The
333.11 commissioner shall recover one-half of the
333.12 funds by February 1, 2010, and the remainder
333.13 by February 1, 2011. At the commissioner's
333.14 discretion and at the request of a county
333.15 or tribe, the commissioner may revise
333.16 the payment schedule, but full payment
333.17 must not be delayed beyond May 1, 2011.
333.18 The commissioner may use the recovery
333.19 procedure under Minnesota Statutes, section
333.20 256.017, to recover the funds. Recovered
333.21 funds must be deposited into the general
333.22 fund.

333.23 **(h) General Assistance Grants**	49,315,000	49,708,000

333.24 **General Assistance Standard.** The
333.25 commissioner shall set the monthly standard
333.26 of assistance for general assistance units
333.27 consisting of an adult recipient who is
333.28 childless and unmarried or living apart
333.29 from parents or a legal guardian at $203.
333.30 The commissioner may reduce this amount
333.31 according to Laws 1997, chapter 85, article
333.32 3, section 54.

333.33 **Combining Emergency Assistance for**
333.34 **MSA and GA.** The amount appropriated
333.35 for emergency general assistance funds is

334.1 limited to no more than $8,989,812 in fiscal
334.2 year 2010 and $8,989,812 in fiscal year 2011.
334.3 Funds to counties must be allocated by the
334.4 commissioner using the allocation method
334.5 specified in Minnesota Statutes, section
334.6 256D.06.

334.7 **(i) Minnesota Supplemental Aid Grants**	32,850,000	34,166,000
334.8 **(j) Group Residential Housing Grants**	111,689,000	113,937,000
334.9 **(k) Other Children and Economic Assistance** 334.10 **Grants**	16,342,000	15,339,000

334.11 **Homeless and Runaway Youth.** $238,000
334.12 in fiscal year 2010 is for the Runaway
334.13 and Homeless Youth Act under Minnesota
334.14 Statutes, section 256K.45. Funds shall be
334.15 spent in each area of the continuum of care
334.16 to ensure that programs are meeting the
334.17 greatest need. Any unexpended balance in
334.18 the first year is available in the second year.
334.19 Beginning July 1, 2011, the base is increased
334.20 by $119,000 each year.

334.21 **Foodshelf Programs.** $275,000 in fiscal
334.22 year 2010 is for foodshelf programs under
334.23 Minnesota Statutes, section 256E.34. This
334.24 is a onetime appropriation and is available
334.25 until expended. This appropriation is to
334.26 complement the federal funding under the
334.27 American Recovery and Reinvestment Act.

334.28 **Supportive Housing Services.** $1,500,000
334.29 each year is for supportive services under
334.30 Minnesota Statutes, section 256K.26. This is
334.31 a onetime appropriation. Beginning in fiscal
334.32 year 2012, the base is increased by $68,000
334.33 per year.

334.34 **Community Action Grants.** Community
334.35 action grants are reduced one time by

335.1 $1,764,000 each year. This reduction is due
335.2 to the availability of federal funds under the
335.3 American Recovery and Reinvestment Act.

335.4 **(l) Children's Mental Health Grants**	16,885,000	16,882,000

335.5 **Funding Usage.** Up to 75 percent of a fiscal
335.6 year's appropriation for children's mental
335.7 health grants may be used to fund allocations
335.8 in that portion of the fiscal year ending
335.9 December 31.

335.10 Subd. 5. **Children and Economic Assistance**
335.11 **Management**

335.12 The amounts that may be spent from the
335.13 appropriation for each purpose are as follows:

335.14 **(a) Children and Economic Assistance**
335.15 **Administration**

335.16 Appropriations by Fund		
335.17 General	10,218,000	10,208,000
335.18 Federal TANF	496,000	496,000

335.19 **(b) Children and Economic Assistance**
335.20 **Operations**

335.21 Appropriations by Fund		
335.22 General	33,773,000	33,423,000
335.23 Health Care Access	361,000	361,000

335.24 **Financial Institution Data Match and**
335.25 **Payment of Fees.** The commissioner is
335.26 authorized to allocate up to $310,000 each
335.27 year in fiscal years 2010 and 2011 from the
335.28 PRISM special revenue account to make
335.29 payments to financial institutions in exchange
335.30 for performing data matches between account
335.31 information held by financial institutions
335.32 and the public authority's database of child
335.33 support obligors as authorized by Minnesota
335.34 Statutes, section 13B.06, subdivision 7.

335.35 Subd. 6. **Basic Health Care Grants**

336.1 **ARRA Food Support Administration.**
336.2 The funds available for food support
336.3 administration under American Recovery
336.4 and Reinvestment Act of 2009 must
336.5 be appropriated to the commissioner
336.6 for implementing the food support benefit
336.7 increases, increased eligibility determinations
336.8 and outreach. Of these funds, 20 percent
336.9 shall be allocated to the commissioner and
336.10 80 percent must be allocated to counties.
336.11 The commissioner shall reimburse counties
336.12 proportionate to their food support caseload
336.13 based on data for the most recent quarter
336.14 available. Tribal reimbursement must be
336.15 made from the state portion based on a
336.16 caseload factor equivalent to that of a county.

336.17 **Expenditure Limit; Critical Access Dental.**
336.18 For calendar years beginning on or after
336.19 January 1, 2010, the commissioner shall limit
336.20 annual expenditures for the critical access
336.21 dental provider program under Minnesota
336.22 Statutes, sections 256B.76, subdivisions
336.23 4 and 4a, and 256L.11, subdivision 7, to
336.24 75 percent of the expenditure level for the
336.25 calendar year ending December 31, 2008.

336.26 The amounts that may be spent from this
336.27 appropriation for each purpose are as follows:

336.28 **(a) MinnesotaCare Grants**	414,258,000	500,972,000

336.29 This appropriation is from the health care
336.30 access fund.

336.31 **(b) MA Basic Health Care Grants - Families** 336.32 **and Children**	755,232,000	983,066,000

336.33 **Medical Education Research Costs**
336.34 **(MERC).** Of these funds, the commissioner
336.35 of human services shall transfer $38,000,000

337.1 in fiscal year 2010 to the medical education
337.2 research fund. These funds must restore the
337.3 fiscal year 2009 unallotment of the transfers
337.4 under Minnesota Statutes, section 256B.69,
337.5 subdivision 5c, paragraph (a), for the July 1,
337.6 2008, through June 30, 2009, period.

337.7 **Local Share Payment Modification**
337.8 **Required for ARRA Compliance.**
337.9 Effective retroactively from October 1, 2008,
337.10 to June 30, 2009, the state shall reduce
337.11 Hennepin County's monthly contribution to
337.12 the nonfederal share of medical assistance
337.13 costs to the percentage required on September
337.14 1, 2008, to meet federal requirements for
337.15 enhanced federal match under the American
337.16 Reinvestment and Recovery Act of 2009.
337.17 Notwithstanding the requirements of
337.18 Minnesota Statutes 2008, section 256B.19,
337.19 subdivision 1c, paragraph (d), for the period
337.20 beginning October 1, 2008, to June 30, 2009,
337.21 Hennepin County's monthly payment under
337.22 that provision is reduced to $434,688.

337.23 **Capitation Payments.** Effective
337.24 retroactively from October 1, 2008, to
337.25 December 31, 2010, and notwithstanding
337.26 the requirements of Minnesota Statutes
337.27 2008, section 256B.19, subdivision 1c,
337.28 paragraph (c), the commissioner of human
337.29 services shall increase capitation payments
337.30 made to the Metropolitan Health Plan
337.31 under Minnesota Statutes 2008, section
337.32 256B.69, by $6,800,000 to recognize higher
337.33 than average medical education costs. The
337.34 increased amount includes federal matching
337.35 money.

338.1 **(c) MA Basic Health Care Grants - Elderly and**
338.2 **Disabled** 969,033,000 1,177,128,000

338.3 **(d) General Assistance Medical Care Grants**

338.4 Appropriations by Fund

338.5 General	237,043,000	380,536,000
338.6 Federal	104,300,000	0

338.7 **Use of Federal Funds.** $99,300,000 in fiscal
338.8 year 2010 is appropriated from the fiscal
338.9 stabilization funds in the federal fund. This
338.10 is a onetime appropriation.

338.11 **(e) Other Health Care Grants**

338.12 Appropriations by Fund

338.13 General	295,000	295,000
338.14 Health Care Access	940,000	190,000

338.15 Subd. 7. **Health Care Management**

338.16 The amounts that may be spent from the
338.17 appropriation for each purpose are as follows:

338.18 **(a) Health Care Administration**

338.19 Appropriations by Fund

338.20 General	7,779,000	7,535,000
338.21 Health Care Access	1,812,000	906,000

338.22 **(b) Health Care Operations**

338.23 Appropriations by Fund

338.24 General	19,902,000	18,869,000
338.25 Health Care Access	24,753,000	25,578,000

338.26 **Base Adjustment.** The health care access
338.27 fund base is decreased by $62,000 in fiscal
338.28 year 2012 and $149,000 in fiscal year 2013.
338.29 The general fund base is decreased by
338.30 $157,000 in fiscal year 2012 and $157,000 in
338.31 fiscal year 2013.

338.32 Subd. 8. **Continuing Care Grants**

339.1 The amounts that may be spent from the
339.2 appropriation for each purpose are as follows:

339.3 **(a) Aging and Adult Services Grants**

339.4	Appropriations by Fund	
339.5 General	13,186,000	13,702,000
339.6 Federal	500,000	0

339.7 **Base Adjustment.** The general fund base is
339.8 increased by $6,643,000 in fiscal year 2012
339.9 and $7,511,000 in fiscal year 2013.

339.10 **Information and Assistance**
339.11 **Reimbursement.** Federal administrative
339.12 reimbursement obtained from information
339.13 and assistance services provided by the
339.14 Senior LinkAge or Disability Linkage lines
339.15 to people who are identified as eligible for
339.16 medical assistance shall be appropriated to
339.17 the commissioner for this activity.

339.18 **Community Service Development Grant**
339.19 **Reduction.** Funding for community service
339.20 development grants must be reduced by
339.21 $240,000 per year for fiscal years 2010 and
339.22 2011. This reduction shall not adjust the base
339.23 appropriation.

339.24 **Senior Nutrition Use of Federal Funds.**
339.25 For fiscal year 2010, general fund grants
339.26 for home-delivered meals and congregate
339.27 dining shall be reduced by $500,000. The
339.28 commissioner must replace these general
339.29 fund reductions with equal amounts from
339.30 federal funding for senior nutrition from the
339.31 American Recovery and Reinvestment Act
339.32 of 2009.

339.33 **(b) Alternative Care Grants** 51,165,000 50,976,000

340.1 **Base Adjustment.** The general fund base is
340.2 decreased by $6,068,000 in fiscal year 2012
340.3 and $6,449,000 in fiscal year 2013.

340.4 **Alternative Care Transfer.** Any money
340.5 allocated to the alternative care program that
340.6 is not spent for the purposes indicated does
340.7 not cancel but must be transferred to the
340.8 medical assistance account.

340.9 **(c) Medical Assistance Grants; Long-Term** 340.10 **Care Facilities.**	366,999,000	427,491,000
340.11 **(d) Medical Assistance Long-Term Care** 340.12 **Waivers and Home Care Grants**	853,824,000	1,044,549,000

340.13 **Manage Growth in TBI and CADI**
340.14 **Waivers.** During the fiscal years beginning
340.15 on July 1, 2011, and July 1, 2012, the
340.16 commissioner shall allocate money for home
340.17 and community-based waiver programs
340.18 under Minnesota Statutes, section 256B.49,
340.19 to ensure a reduction in state spending that is
340.20 equivalent to limiting the caseload growth of
340.21 the TBI waiver to 12.5 allocations per month
340.22 each year of the biennium and the CADI
340.23 waiver to 95 allocations per month each year
340.24 of the biennium. Limits do not apply: (1)
340.25 when there is an approved plan for nursing
340.26 facility bed closures for individuals under
340.27 age 65 who require relocation due to the
340.28 bed closure; (2) to fiscal year 2009 waiver
340.29 allocations delayed due to unallotment; or (3)
340.30 to transfers authorized by the commissioner
340.31 from the personal care assistance program
340.32 of individuals having a home care rating
340.33 of "CS," "MT," or "HL." Priorities for the
340.34 allocation of funds must be for individuals
340.35 anticipated to be discharged from institutional

341.1 settings or who are at imminent risk of a
341.2 placement in an institutional setting.

341.3 **Manage Growth in DD Waiver.** The
341.4 commissioner shall manage the growth in
341.5 the DD waiver by limiting the allocations
341.6 included in the February 2009 forecast to 15
341.7 additional diversion allocations each month
341.8 for the calendar years that begin on January
341.9 1, 2012, and January 1, 2013. Additional
341.10 allocations must be made available for
341.11 transfers authorized by the commissioner
341.12 from the personal care program of individuals
341.13 having a home care rating of "CS," "MT,"
341.14 or "HL."

341.15 **Adjustment to Lead Agency Waiver**
341.16 **allocations.** Prior to the availability of the
341.17 alternative license defined in Minnesota
341.18 Statutes, section 245A.11, subdivision 8,
341.19 the commissioner shall reduce lead agency
341.20 waiver allocations for the purposes of
341.21 implementing a moratorium on corporate
341.22 foster care.

341.23 **(e) Mental Health Grants**

341.24	Appropriations by Fund		
341.25	General	75,089,000	77,539,000
341.26	Health Care Access	750,000	750,000
341.27	Lottery Prize	1,508,000	1,508,000

341.28 **Funding Usage.** Up to 75 percent of a fiscal
341.29 year's appropriation for adult mental health
341.30 grants may be used to fund allocations in that
341.31 portion of the fiscal year ending December
341.32 31.

341.33 **Base Adjustment.** The general fund base is
341.34 reduced by $525,000 in fiscal year 2012 and
341.35 $525,000 is fiscal year 2013.

(f) Deaf and Hard-of-Hearing Grants	1,924,000	1,909,000
(g) Chemical Dependency Entitlement Grants	110,660,000	120,509,000

Payments for Substance Abuse Treatment. For services provided in fiscal years 2010 and 2011, county-negotiated rates and provider claims to the consolidated chemical dependency fund must not exceed rates charged for services in excess of those in effect on January 1, 2009. If statutes authorize a cost-of-living adjustment during fiscal years 2010 and 2011, then notwithstanding any law to the contrary, fiscal years 2010 and 2011 rates must not exceed those in effect on January 2, 2009, plus any authorized cost-of-living adjustments.

Chemical Dependency Special Revenue Account. For fiscal year 2010, $750,000 must be transferred from the consolidated chemical dependency treatment fund administrative account and deposited into the general fund.

County CD Share of MA Costs for ARRA Compliance. Notwithstanding the provisions of Minnesota Statutes, chapter 254B, for chemical dependency services provided during the period July 1, 2009, to December 31, 2010, and reimbursed by medical assistance at the enhanced federal matching rate provided under the American Recovery and Reinvestment Act of 2009, the county share is 30 percent of the nonfederal share.

(h) Chemical Dependency Nonentitlement Grants	1,729,000	1,729,000

343.1 **(i) Other Continuing Care Grants** 18,608,000 13,441,000

343.2 **Base Adjustment.** The general fund base is
343.3 decreased $1,076,000 in fiscal year 2012 and
343.4 decreased $2,005,000 in fiscal year 2013.

343.5 **Other Continuing Care Grants; HIV**
343.6 **Grants.** Money appropriated for the HIV
343.7 drug and insurance grant program in fiscal
343.8 year 2010 may be used in either year of the
343.9 biennium.

343.10 Subd. 9. **Continuing Care Management**

343.11	Appropriations by Fund		
343.12	General	24,571,000	24,275,000
343.13 343.14	State Government Special Revenue	875,000	125,000
343.15	Lottery Prize	157,000	157,000

343.16 **County Maintenance of Effort.** $350,000 in
343.17 fiscal year 2010 is from the general fund for
343.18 the State-County Results Accountability and
343.19 Service Delivery Reform under Minnesota
343.20 Statutes, chapter 402A.

343.21 The general fund base is decreased
343.22 $2,211,000 in fiscal year 2012 and
343.23 $2,156,000 in fiscal year 2013.

343.24 Subd. 10. **State-Operated Services** 258,794,000 266,191,000

343.25 The amounts that may be spent from the
343.26 appropriation for each purpose are as follows:

343.27 **Transfer Authority Related to**
343.28 **State-Operated Services.** Money
343.29 appropriated to finance state-operated
343.30 services may be transferred between the
343.31 fiscal years of the biennium with the approval
343.32 of the commissioner of finance.

343.33 **County Past Due Receivables.** The
343.34 commissioner is authorized to withhold

344.1 county federal administrative reimbursement
344.2 when the county of financial responsibility
344.3 for cost-of-care payments due the state
344.4 under Minnesota Statutes, section 246.54
344.5 or 253B.045, is 90 days past due. The
344.6 commissioner shall deposit the withheld
344.7 federal administrative earnings for the county
344.8 into the general fund to settle the claims with
344.9 the county of financial responsibility. The
344.10 process for withholding funds is governed by
344.11 Minnesota Statutes, section 256.017.

344.12 **(a) Adult Mental Health Services**	110,216,000	114,953,000

344.13 **Appropriation Limitation.** No part of
344.14 the appropriation in this article to the
344.15 commissioner for mental health treatment
344.16 services provided by state-operated services
344.17 shall be used for the Minnesota sex offender
344.18 program.

344.19 **Community Behavioral Health Hospitals.**
344.20 Under Minnesota Statutes, section 246.51,
344.21 subdivision 1, a determination order for the
344.22 clients served in a community behavioral
344.23 health hospital operated by the commissioner
344.24 of human services is only required when
344.25 a client's third-party coverage has been
344.26 exhausted.

344.27 **(b) Minnesota Sex Offender Services**	64,843,000	67,503,000
344.28 **(c) Minnesota Security Hospital and METO** 344.29 **Services**	83,735,000	83,735,000

344.30 **Minnesota Security Hospital.** For the
344.31 purposes of enhancing the safety of
344.32 the public, improving supervision, and
344.33 enhancing community-based mental health
344.34 treatment, state-operated services may
344.35 establish additional community capacity

345.1 for providing treatment and supervision
345.2 of clients who have been ordered into a
345.3 less restrictive alternative of care from the
345.4 state-operated services transitional services
345.5 program consistent with Minnesota Statutes,
345.6 section 246.014.

345.7 Sec. 4. **COMMISSIONER OF HEALTH**

345.8 Subdivision 1. **Total Appropriation** **$ 165,590,000 $ 161,787,000**

345.9 Appropriations by Fund		
345.10	2010	2011
345.11 General	73,699,000	64,171,000
345.12 State Government 345.13 Special Revenue	45,433,000	45,789,000
345.14 Health Care Access	34,725,000	40,094,000
345.15 Federal TANF	11,733,000	11,733,000

345.16 Subd. 2. **Community and Family Health**
345.17 **Promotion**

345.18 Appropriations by Fund		
345.19 General	43,761,000	38,501,000
345.20 State Government 345.21 Special Revenue	1,033,000	1,304,000
345.22 Federal TANF	11,733,000	11,733,000
345.23 Health Care Access	21,642,000	28,719,000

345.24 **Support Services for Families With**
345.25 **Children Who are Deaf or Have Hearing**
345.26 **Loss.** Of the state government special
345.27 revenue fund amount, $18,000 in fiscal year
345.28 2010 and $271,000 in fiscal year 2011 is for
345.29 support services to families with children
345.30 who are deaf or have hearing loss. Of this
345.31 amount, in fiscal year 2011, $198,000 is for
345.32 grants and the balance is for administrative
345.33 costs. Base funding in fiscal years 2012 and
345.34 2013 is $288,000 each year. Of this amount,
345.35 $215,000 each year is for grants and the
345.36 balance is for administrative costs.

346.1 **Funding Usage.** Up to 75 percent of the
346.2 fiscal year 2012 appropriation for local public
346.3 health grants may be used to fund calendar
346.4 year 2011 allocations for this program. The
346.5 general fund reduction of $5,060,000 in
346.6 fiscal year 2011 for local public health grants
346.7 is onetime and the base funding for local
346.8 public health grants for fiscal year 2012 is
346.9 increased by $5,060,000.

346.10 **Grants Reduction.** Effective July 1,
346.11 2009, base-level funding for general fund
346.12 community and family health grants issued
346.13 under this paragraph shall be reduced by
346.14 2.55 percent at the allotment level. Effective
346.15 July 1, 2011, base-level funding for general
346.16 fund community and family health grants
346.17 issued under this paragraph shall be reduced
346.18 by 5.5 percent at the allotment level. The
346.19 positive alternatives grant is exempt from
346.20 this reduction. The base for the positive
346.21 alternatives grant is $2,357,000 per year.

346.22 **Colorectal Screening.** $100,000 in
346.23 fiscal year 2010 is for grants to the
346.24 Hennepin County Medical Center and
346.25 MeritCare Bemidji for colorectal screening
346.26 demonstration projects.

346.27 **Women's Heart Health Pilot Project.**
346.28 $100,000 in fiscal year 2010 is for the
346.29 women's heart health pilot project. This is a
346.30 onetime appropriation and is available until
346.31 expended.

346.32 **Feasibility Pilot Project for Cancer**
346.33 **Surveillance.** Of this appropriation for fiscal
346.34 year 2010, the commissioner of health must
346.35 provide grant funding from the Department

347.1 of Health's current resources for the Chronic
347.2 Disease and Environmental Epidemiology
347.3 section. The grant must cover the cost of one
347.4 full-time equivalent position at the Hennepin
347.5 County Medical Center. The grant must
347.6 be sufficient to cover the responsibilities
347.7 associated with carrying out the feasibility
347.8 pilot project but shall not exceed $100,000.

347.9 **TANF Appropriations.** (1) $1,156,000 of
347.10 the TANF funds are appropriated each year to
347.11 the commissioner for family planning grants
347.12 under Minnesota Statutes, section 145.925.

347.13 (2) $3,579,000 of the TANF funds are
347.14 appropriated each year to the commissioner
347.15 for home visiting and nutritional services
347.16 listed under Minnesota Statutes, section
347.17 145.882, subdivision 7, clauses (6) and (7).
347.18 Funds must be distributed to community
347.19 health boards according to Minnesota
347.20 Statutes, section 145A.131, subdivision 1.

347.21 (3) $2,000,000 of the TANF funds are
347.22 appropriated each year to the commissioner
347.23 for decreasing racial and ethnic disparities
347.24 in infant mortality rates under Minnesota
347.25 Statutes, section 145.928, subdivision 7.

347.26 (4) $4,998,000 of the TANF funds are
347.27 appropriated each year to the commissioner
347.28 for the family home visiting grant program
347.29 according to Minnesota Statutes, section
347.30 145A.17. $4,000,000 of the funding must
347.31 be distributed to community health boards
347.32 according to Minnesota Statutes, section
347.33 145A.131, subdivision 1. $998,000 of
347.34 the funding must be distributed to tribal
347.35 governments according to Minnesota

348.1 Statutes, section 145A.14, subdivision 2a.
348.2 The commissioner may use five percent of
348.3 the funds appropriated each fiscal year to
348.4 conduct the ongoing evaluations required
348.5 under Minnesota Statutes, section 145A.17,
348.6 subdivision 7, and may use ten percent of
348.7 the funds appropriated each fiscal year to
348.8 provide training and technical assistance as
348.9 required under Minnesota Statutes, section
348.10 145A.17, subdivisions 4 and 5.

348.11 **TANF Carryforward.** Any unexpended
348.12 balance of the TANF appropriation in the
348.13 first year of the biennium does not cancel but
348.14 is available for the second year.

348.15 Subd. 3. **Policy Quality and Compliance**

	Appropriations by Fund		
348.17	General	13,069,000	8,801,000
348.18 348.19	State Government Special Revenue	14,173,000	14,276,000
348.20	Health Care Access	13,083,000	11,375,000

348.21 **Rural Pharmacy Planning.** $100,000 in
348.22 fiscal year 2010 is for the rural pharmacy
348.23 planning and transition grant program under
348.24 Minnesota Statutes, section 144.1476. The
348.25 appropriation is available until expended.

348.26 **Value-Based Insurance Designs.** The
348.27 commissioner of health, in consultation
348.28 with the commissioner of human services,
348.29 commerce, and Minnesota management
348.30 and budget, shall study and report to the
348.31 legislature on value-based insurance designs
348.32 that vary enrollee cost-sharing based on
348.33 clinical or cost-effectiveness of services.
348.34 In performing this study, the commissioner
348.35 shall consult with and seek input from
348.36 health plans, health care providers, and

349.1 employers. The commissioner shall report to
349.2 the legislature by January 15, 2010.

349.3 **Health Information Technology.** Of the
349.4 general fund appropriation, $4,000,000 is
349.5 to fund the revolving loan account under
349.6 Minnesota Statutes, section 62J.496. This
349.7 appropriation must not be expended unless
349.8 it is matched with federal funding under the
349.9 federal Health Information Technology for
349.10 Economic and Clinical Health (HITECH)
349.11 Act. This appropriation must not be included
349.12 in the agency's base budget for the fiscal year
349.13 beginning July 1, 2012.

349.14 **Base Adjustment.** The general fund
349.15 base is $8,801,000 in fiscal year 2012 and
349.16 $8,593,000 in fiscal year 2013. The health
349.17 care access fund base is $10,775,000 in fiscal
349.18 year 2012 and $6,641,000 in fiscal year 2013.
349.19 The state government special revenue fund
349.20 base is $14,234,000 for each of fiscal years
349.21 2012 and 2013.

349.22 Subd. 4. **Health Protection**

349.23 Appropriations by Fund

349.24	General	9,679,000	9,679,000
349.25 349.26	State Government Special Revenue	30,227,000	30,209,000

349.27 **Grants Reduction.** Effective July 1,
349.28 2009, base-level funding for general fund
349.29 health protection grants issued under this
349.30 paragraph shall be reduced by 2.55 percent
349.31 at the allotment level. Effective July 1,
349.32 2011, base-level funding for general fund
349.33 health protection grants issued under this
349.34 paragraph shall be reduced by 5.5 percent at
349.35 the allotment level.

350.1 **Session Laws Adjustment.** (a) $163,000
350.2 each year is for the lead abatement grant
350.3 program. This adjustment is onetime.

350.4 (b) $100,000 each year is for emergency
350.5 preparedness and response activities. This
350.6 adjustment is onetime. Of this amount,
350.7 $50,000 each year is for tuberculosis
350.8 prevention and control.

350.9 Subd. 5. **Administrative Support Services**		7,190,000		7,190,000

350.10 Sec. 5. **HEALTH-RELATED BOARDS**

350.11 Subdivision 1. **Total Appropriation**	**$**	**14,753,000**	**$**	**15,036,000**

350.12 This appropriation is from the state
350.13 government special revenue fund.

350.14 **Transfer From Special Revenue Fund.**
350.15 During the fiscal year beginning July 1, 2011,
350.16 the commissioner of finance shall transfer
350.17 $10,000,000 from the state government
350.18 special revenue fund to the general fund. The
350.19 boards must allocate this reduction to boards
350.20 carrying a positive balance as of July 1, 2011.

350.21 The amounts that may be spent for each
350.22 purpose are specified in the following
350.23 subdivisions.

350.24 Subd. 2. **Board of Chiropractic Examiners**	492,000	509,000
350.25 Subd. 3. **Board of Dentistry**	1,100,000	1,136,000
350.26 Subd. 4. **Board of Dietetic and Nutrition** 350.27 **Practice**	105,000	105,000
350.28 Subd. 5. **Board of Marriage and Family** 350.29 **Therapy**	159,000	167,000
350.30 Subd. 6. **Board of Medical Practice**	3,682,000	3,682,000
350.31 Subd. 7. **Board of Nursing**	3,368,000	3,521,000
350.32 Subd. 8. **Board of Nursing Home** 350.33 **Administrators**	1,358,000	1,262,000

351.1 **Administrative Services Unit - Operating**
351.2 **Costs.** Of this appropriation, $524,000
351.3 in fiscal year 2010 and $526,000 in
351.4 fiscal year 2011 are for operating costs
351.5 of the administrative services unit. The
351.6 administrative services unit may receive
351.7 and expend reimbursements for services
351.8 performed by other agencies.

351.9 **Administrative Services Unit - Retirement**
351.10 **Costs.** Of this appropriation in fiscal year
351.11 2010, $201,000 is for onetime retirement
351.12 costs in the health-related boards. This
351.13 funding may be transferred to the health
351.14 boards incurring those costs for their
351.15 payment. These funds are available either
351.16 year of the biennium.

351.17 **Administrative Services Unit - Volunteer**
351.18 **Health Care Provider Program.** Of this
351.19 appropriation, $79,000 in fiscal year 2010
351.20 and $89,000 in fiscal year 2011 are to pay
351.21 for medical professional liability coverage
351.22 required under Minnesota Statutes, section
351.23 214.40.

351.24 **Administrative Services Unit - Contested**
351.25 **Cases and Other Legal Proceedings.** Of
351.26 this appropriation, $200,000 in fiscal year
351.27 2010 and $200,000 in fiscal year 2011
351.28 are for costs of contested case hearings
351.29 and other unanticipated costs of legal
351.30 proceedings involving health-related
351.31 boards funded under this section. Upon
351.32 certification of a health-related board to the
351.33 administrative services unit that the costs
351.34 will be incurred and that there is insufficient
351.35 money available to pay for the costs out of

352.1 money currently available to that board, the
352.2 administrative services unit is authorized
352.3 to transfer money from this appropriation
352.4 to the board for payment of those costs
352.5 with the approval of the commissioner of
352.6 finance. This appropriation does not cancel.
352.7 Any unencumbered and unspent balances
352.8 remain available for these expenditures in
352.9 subsequent fiscal years.

352.10	Subd. 9. **Board of Optometry**	105,000	108,000
352.11	Subd. 10. **Board of Pharmacy**	1,509,000	1,579,000
352.12	Subd. 11. **Board of Physical Therapy**	346,000	356,000
352.13	Subd. 12. **Board of Podiatry**	61,000	64,000
352.14	Subd. 13. **Board of Psychology**	876,000	907,000
352.15	Subd. 14. **Board of Social Work**	958,000	996,000
352.16	Subd. 15. **Board of Veterinary Medicine**	240,000	250,000
352.17 352.18	Subd. 16. **Board of Behavioral Health and Therapy**	394,000	394,000

352.19 Sec. 6. **EMERGENCY MEDICAL SERVICES**
352.20 **BOARD** **$ 4,024,000 $ 4,054,000**

352.21 Appropriations by Fund

		2010	2011
352.23	General	3,288,000	3,288,000
352.24 352.25	State Government Special Revenue	736,000	766,000
352.26 352.27 352.28	Cooper/Sams Volunteer Ambulance Trust	625,000	0

352.29 **Longevity Award and Incentive Program.**
352.30 Of the general fund appropriation, $700,000
352.31 in fiscal year 2010 and $700,000 in fiscal
352.32 year 2011 are to the board for the ambulance
352.33 service personnel longevity award and
352.34 incentive program, under Minnesota Statutes,
352.35 section 144E.40.

353.1 **Transfer.** In fiscal year 2010, $626,000
353.2 is transferred from the Cooper/Sams
353.3 volunteer ambulance trust, established under
353.4 Minnesota Statutes, section 144E.42, to the
353.5 general fund.

353.6 **Health Professional Services Program.**
353.7 $736,000 in fiscal year 2010 and $766,000 in
353.8 fiscal year 2011 from the state government
353.9 special revenue fund are for the health
353.10 professional services program.

353.11 **Regional Medical Services Program.** (a)
353.12 $400,000 in the first year is transferred from
353.13 the Cooper/Sams volunteer ambulance trust
353.14 to the emergency medical services system
353.15 fund.

353.16 (b) $400,000 in the first year from the
353.17 emergency medical services system fund is
353.18 for the regional emergency medical services
353.19 programs. This amount shall be distributed
353.20 equally to the eight emergency medical
353.21 service regions. Notwithstanding Minnesota
353.22 Statutes, section 144E.50, 100 percent of
353.23 the appropriation shall be passed on to the
353.24 emergency medical service regions.

353.25 **Comprehensive Advanced Life-Support**
353.26 **Educational (CALS) Program.** $100,000 in
353.27 the first year from the Cooper/Sams volunteer
353.28 ambulance trust is for the comprehensive
353.29 advanced life-support educational (CALS)
353.30 program established under Minnesota
353.31 Statutes, section 144E.37. This appropriation
353.32 is to extend availability and affordability
353.33 of the CALS program for rural emergency
353.34 medical personnel and to assist hospital staff
353.35 in attaining the credentialing levels necessary

354.1 for implementation of the statewide trauma
354.2 system.

354.3 **Emergency Medical Services for Children**
354.4 **(EMS-C) Program.** $25,000 in the first
354.5 year from the Cooper/Sams volunteer
354.6 ambulance trust is for the emergency medical
354.7 services for children (EMS-C) program.
354.8 This appropriation is to meet increased need
354.9 for medical training specific to pediatric
354.10 emergencies.

354.11 Sec. 7. **DEPARTMENT OF VETERANS** 354.12 **AFFAIRS**	**$**	**200,000**	**$**	**0**

354.13 **Veterans Paramedic Apprenticeship**
354.14 **Program.** $200,000 in the first year is from
354.15 the Cooper/Sams volunteer ambulance trust
354.16 to the commissioner of veterans affairs
354.17 for a grant to the Minnesota Ambulance
354.18 Association to implement a veterans
354.19 paramedic apprenticeship program to
354.20 reintegrate returning military medics into
354.21 Minnesota's workforce in the field of
354.22 paramedic and emergency services, thereby
354.23 guaranteeing returning military medics
354.24 gainful employment with livable wages and
354.25 benefits. This appropriation is available until
354.26 expended.

354.27 Sec. 8. **DEPARTMENT OF PUBLIC SAFETY**	**$**	**250,000**	**$**	**0**

354.28 **Medical Response Unit Reimbursement**
354.29 **Pilot Program.** (a) $250,000 in the first
354.30 year is from the Cooper/Sams volunteer
354.31 ambulance trust to the Department of
354.32 Public Safety for a medical response unit
354.33 reimbursement pilot program. Of this
354.34 appropriation, $75,000 is for administrative

355.1 costs to the Department of Public Safety,
355.2 including providing contract staff support
355.3 and technical assistance to the pilot program
355.4 partners if necessary.

355.5 (b) Of the amount in paragraph (a), $175,000
355.6 is to the Department of Public Safety
355.7 to be used to provide a predetermined
355.8 reimbursement amount to the participating
355.9 medical response units. The Department
355.10 of Public Safety or its contract designee
355.11 will develop an agreement with the medical
355.12 response units outlining reimbursement and
355.13 program requirements to include HIPAA
355.14 compliance while participating in the pilot
355.15 program.

355.16 Sec. 9. **COUNCIL ON DISABILITY**	**$**	**524,000**	**$**	**524,000**
355.17 Sec. 10. **OMBUDSMAN FOR MENTAL** 355.18 **HEALTH AND DEVELOPMENTAL** 355.19 **DISABILITIES**	**$**	**1,655,000**	**$**	**1,580,000**
355.20 Sec. 11. **OMBUDSPERSON FOR FAMILIES**	**$**	**265,000**	**$**	**265,000**

355.21 Sec. 12. Laws 2007, chapter 147, article 19, section 3, subdivision 4, as amended
355.22 by Laws 2008, chapter 277, article 5, section 1; and Laws 2008, chapter 363, article
355.23 18, section 7, is amended to read:

355.24 Subd. 4. **Children and Economic Assistance**
355.25 **Grants**

355.26 The amounts that may be spent from this
355.27 appropriation for each purpose are as follows:

355.28 (a) **MFIP/DWP Grants**

355.29 Appropriations by Fund

355.30 General	62,069,000	62,405,000
355.31 Federal TANF	75,904,000	80,841,000

355.32 (b) **Support Services Grants**

356.1 Appropriations by Fund

356.2 General	8,715,000	8,715,000
356.3 Federal TANF	113,429,000	115,902,000

356.4 **TANF Prior Appropriation Cancellation.**
356.5 Notwithstanding Laws 2001, First Special
356.6 Session chapter 9, article 17, section
356.7 2, subdivision 11, paragraph (b), any
356.8 unexpended TANF funds appropriated to the
356.9 commissioner to contract with the Board of
356.10 Trustees of Minnesota State Colleges and
356.11 Universities, to provide tuition waivers to
356.12 employees of health care and human service
356.13 providers that are members of qualifying
356.14 consortia operating under Minnesota
356.15 Statutes, sections 116L.10 to 116L.15, must
356.16 cancel at the end of fiscal year 2007.

356.17 **MFIP Pilot Program.** Of the TANF
356.18 appropriation, $100,000 in fiscal year 2008
356.19 and $750,000 in fiscal year 2009 are for a
356.20 grant to the Stearns-Benton Employment and
356.21 Training Council for the Workforce U pilot
356.22 program. Base level funding for this program
356.23 shall be $750,000 in 2010 and $0 in 2011.

356.24 **Supported Work.** (1) Of the TANF
356.25 appropriation, $5,468,000 in fiscal year 2008
356.26 is for supported work for MFIP participants,
356.27 to be allocated to counties and tribes based
356.28 on the criteria under clauses (2) and (3), and
356.29 is available until expended. Paid transitional
356.30 work experience and other supported
356.31 employment under this rider provides
356.32 a continuum of employment assistance,
356.33 including outreach and recruitment,
356.34 program orientation and intake, testing and
356.35 assessment, job development and marketing,

357.1 preworksite training, supported worksite
357.2 experience, job coaching, and postplacement
357.3 follow-up, in addition to extensive case
357.4 management and referral services. *** (The**
357.5 **preceding text "and $7,291,000 in fiscal**
357.6 **year 2009" was indicated as vetoed by the**
357.7 **governor.)**

357.8 (2) A county or tribe is eligible to receive an
357.9 allocation under this rider if:

357.10 (i) the county or tribe is not meeting the
357.11 federal work participation rate;

357.12 (ii) the county or tribe has participants who
357.13 are required to perform work activities under
357.14 Minnesota Statutes, chapter 256J, but are not
357.15 meeting hourly work requirements; and

357.16 (iii) the county or tribe has assessed
357.17 participants who have completed six weeks
357.18 of job search or are required to perform
357.19 work activities and are not meeting the
357.20 hourly requirements, and the county or tribe
357.21 has determined that the participant would
357.22 benefit from working in a supported work
357.23 environment.

357.24 (3) A county or tribe may also be eligible for
357.25 funds in order to contract for supplemental
357.26 hours of paid work at the participant's child's
357.27 place of education, child care location, or the
357.28 child's physical or mental health treatment
357.29 facility or office. This grant to counties and
357.30 tribes is specifically for MFIP participants
357.31 who need to work up to five hours more
357.32 per week in order to meet the hourly work
357.33 requirement, and the participant's employer
357.34 cannot or will not offer more hours to the
357.35 participant.

358.1 **Work Study.** Of the TANF appropriation,
358.2 $750,000 each year are to the commissioner
358.3 to contract with the Minnesota Office of
358.4 Higher Education for the biennium beginning
358.5 July 1, 2007, for work study grants under
358.6 Minnesota Statutes, section 136A.233,
358.7 specifically for low-income individuals who
358.8 receive assistance under Minnesota Statutes,
358.9 chapter 256J, and for grants to opportunities
358.10 industrialization centers. * **(The preceding**
358.11 **text beginning "Work Study. Of the TANF**
358.12 **appropriation," was indicated as vetoed**
358.13 **by the governor.)**

358.14 **Integrated Service Projects.** $2,500,000
358.15 in fiscal year 2008 and $2,500,000 in fiscal
358.16 year 2009 are appropriated from the TANF
358.17 fund to the commissioner to continue to
358.18 fund the existing integrated services projects
358.19 for MFIP families, and if funding allows,
358.20 additional similar projects.

358.21 **Base Adjustment.** The TANF base for fiscal
358.22 year 2010 is $115,902,000 and for fiscal year
358.23 2011 is $115,152,000.

358.24 (c) **MFIP Child Care Assistance Grants**

358.25	General	74,654,000	71,951,000

358.26 (d) **Basic Sliding Fee Child Care Assistance**
358.27 **Grants**

358.28	General	42,995,000	45,008,000

358.29 **Base Adjustment.** The general fund base
358.30 is $44,881,000 for fiscal year 2010 and
358.31 $44,852,000 for fiscal year 2011.

358.32 **At-Home Infant Care Program.** No
358.33 funding shall be allocated to or spent on

359.1 the at-home infant care program under
359.2 Minnesota Statutes, section 119B.035.

359.3 (e) **Child Care Development Grants**

359.4 General	4,390,000	6,390,000

359.5 **Prekindergarten Exploratory Projects.** Of
359.6 the general fund appropriation, $2,000,000
359.7 the first year and $4,000,000 the second
359.8 year are for grants to the city of St. Paul,
359.9 Hennepin County, and Blue Earth County to
359.10 establish scholarship demonstration projects
359.11 to be conducted in partnership with the
359.12 Minnesota Early Learning Foundation to
359.13 promote children's school readiness. This
359.14 appropriation is available until June 30, 2009.

359.15 **Child Care Services Grants.** Of this
359.16 appropriation, $250,000 each year are for
359.17 the purpose of providing child care services
359.18 grants under Minnesota Statutes, section
359.19 119B.21, subdivision 5. This appropriation
359.20 is for the 2008-2009 biennium only, and does
359.21 not increase the base funding.

359.22 **Early Childhood Professional**
359.23 **Development System.** Of this appropriation,
359.24 $250,000 each year are for purposes of the
359.25 early childhood professional development
359.26 system, which increases the quality and
359.27 continuum of professional development
359.28 opportunities for child care practitioners.
359.29 This appropriation is for the 2008-2009
359.30 biennium only, and does not increase the
359.31 base funding.

359.32 **Base Adjustment.** The general fund base
359.33 is $1,515,000 for each of fiscal years 2010
359.34 and 2011.

360.1 (f) **Child Support Enforcement Grants**

360.2 General	11,038,000	3,705,000

360.3 **Child Support Enforcement.** $7,333,000
360.4 for fiscal year 2008 is to make grants to
360.5 counties for child support enforcement
360.6 programs to make up for the loss under the
360.7 2005 federal Deficit Reduction Act of federal
360.8 matching funds for federal incentive funds
360.9 passed on to the counties by the state.

360.10 This appropriation is available until June 30,
360.11 2009.

360.12 (g) **Children's Services Grants**

360.13	Appropriations by Fund	
360.14 General	63,647,000	71,147,000
360.15 Health Care Access	250,000	-0-
360.16 TANF	240,000	340,000

360.17 **Grants for Programs Serving Young**
360.18 **Parents.** Of the TANF fund appropriation,
360.19 $140,000 each year is for a grant to a program
360.20 or programs that provide comprehensive
360.21 services through a private, nonprofit agency
360.22 to young parents in Hennepin County who
360.23 have dropped out of school and are receiving
360.24 public assistance. The program administrator
360.25 shall report annually to the commissioner on
360.26 skills development, education, job training,
360.27 and job placement outcomes for program
360.28 participants.

360.29 **County Allocations for Rate Increases.**
360.30 County Children and Community Services
360.31 Act allocations shall be increased by
360.32 $197,000 effective October 1, 2007, and
360.33 $696,000 effective October 1, 2008, to help
360.34 counties pay for the rate adjustments to

361.1 day training and habilitation providers for
361.2 participants paid by county social service
361.3 funds. Notwithstanding the provisions of
361.4 Minnesota Statutes, section 256M.40, the
361.5 allocation to a county shall be based on
361.6 the county's proportion of social services
361.7 spending for day training and habilitation
361.8 services as determined in the most recent
361.9 social services expenditure and grant
361.10 reconciliation report.

361.11 **Privatized Adoption Grants.** Federal
361.12 reimbursement for privatized adoption grant
361.13 and foster care recruitment grant expenditures
361.14 is appropriated to the commissioner for
361.15 adoption grants and foster care and adoption
361.16 administrative purposes.

361.17 **Adoption Assistance Incentive Grants.**
361.18 Federal funds available during fiscal year
361.19 2008 and fiscal year 2009 for the adoption
361.20 incentive grants are appropriated to the
361.21 commissioner for these purposes.

361.22 **Adoption Assistance and Relative Custody**
361.23 **Assistance.** The commissioner may transfer
361.24 unencumbered appropriation balances for
361.25 adoption assistance and relative custody
361.26 assistance between fiscal years and between
361.27 programs.

361.28 **Children's Mental Health Grants.** Of the
361.29 general fund appropriation, $5,913,000 in
361.30 fiscal year 2008 and $6,825,000 in fiscal year
361.31 2009 are for children's mental health grants.
361.32 The purpose of these grants is to increase and
361.33 maintain the state's children's mental health
361.34 service capacity, especially for school-based
361.35 mental health services. The commissioner

362.1 shall require grantees to utilize all available
362.2 third party reimbursement sources as a
362.3 condition of using state grant funds. At
362.4 least 15 percent of these funds shall be
362.5 used to encourage efficiencies through early
362.6 intervention services. At least another 15
362.7 percent shall be used to provide respite care
362.8 services for children with severe emotional
362.9 disturbance at risk of out-of-home placement.

362.10 **Mental Health Crisis Services.** Of the
362.11 general fund appropriation, $2,528,000 in
362.12 fiscal year 2008 and $2,850,000 in fiscal year
362.13 2009 are for statewide funding of children's
362.14 mental health crisis services. Providers must
362.15 utilize all available funding streams.

362.16 **Children's Mental Health Evidence-Based**
362.17 **and Best Practices.** Of the general fund
362.18 appropriation, $375,000 in fiscal year 2008
362.19 and $750,000 in fiscal year 2009 are for
362.20 children's mental health evidence-based and
362.21 best practices including, but not limited
362.22 to: Adolescent Integrated Dual Diagnosis
362.23 Treatment services; school-based mental
362.24 health services; co-location of mental
362.25 health and physical health care, and; the
362.26 use of technological resources to better
362.27 inform diagnosis and development of
362.28 treatment plan development by mental
362.29 health professionals. The commissioner
362.30 shall require grantees to utilize all available
362.31 third-party reimbursement sources as a
362.32 condition of using state grant funds.

362.33 **Culturally Specific Mental Health**
362.34 **Treatment Grants.** Of the general fund
362.35 appropriation, $75,000 in fiscal year 2008

363.1 and $300,000 in fiscal year 2009 are for
363.2 children's mental health grants to support
363.3 increased availability of mental health
363.4 services for persons from cultural and
363.5 ethnic minorities within the state. The
363.6 commissioner shall use at least 20 percent
363.7 of these funds to help members of cultural
363.8 and ethnic minority communities to become
363.9 qualified mental health professionals and
363.10 practitioners. The commissioner shall assist
363.11 grantees to meet third-party credentialing
363.12 requirements and require them to utilize all
363.13 available third-party reimbursement sources
363.14 as a condition of using state grant funds.

363.15 **Mental Health Services for Children with**
363.16 **Special Treatment Needs.** Of the general
363.17 fund appropriation, $50,000 in fiscal year
363.18 2008 and $200,000 in fiscal year 2009 are
363.19 for children's mental health grants to support
363.20 increased availability of mental health
363.21 services for children with special treatment
363.22 needs. These shall include, but not be limited
363.23 to: victims of trauma, including children
363.24 subjected to abuse or neglect, veterans and
363.25 their families, and refugee populations;
363.26 persons with complex treatment needs, such
363.27 as eating disorders; and those with low
363.28 incidence disorders.

363.29 **MFIP and Children's Mental Health**
363.30 **Pilot Project.** Of the TANF appropriation,
363.31 $100,000 in fiscal year 2008 and $200,000
363.32 in fiscal year 2009 are to fund the MFIP
363.33 and children's mental health pilot project.
363.34 Of these amounts, up to $100,000 may be
363.35 expended on evaluation of this pilot.

364.1 ~~**Prenatal Alcohol or Drug Use.** Of the~~
364.2 ~~general fund appropriation, $75,000 each~~
364.3 ~~year is to award grants beginning July 1,~~
364.4 ~~2007, to programs that provide services~~
364.5 ~~under Minnesota Statutes, section 254A.171,~~
364.6 ~~in Pine, Kanabec, and Carlton Counties. This~~
364.7 ~~appropriation shall become part of the base~~
364.8 ~~appropriation.~~

364.9 **Base Adjustment.** The general fund base
364.10 is $62,572,000 in fiscal year 2010 and
364.11 $62,575,000 in fiscal year 2011.

364.12 (h) **Children and Community Services Grants**

364.13 General 101,369,000 69,208,000

364.14 **Base Adjustment.** The general fund base
364.15 is $69,274,000 in each of fiscal years 2010
364.16 and 2011.

364.17 **Targeted Case Management Temporary**
364.18 **Funding.** (a) Of the general fund
364.19 appropriation, $32,667,000 in fiscal year
364.20 2008 is transferred to the targeted case
364.21 management contingency reserve account in
364.22 the general fund to be allocated to counties
364.23 and tribes affected by reductions in targeted
364.24 case management federal Medicaid revenue
364.25 as a result of the provisions in the federal
364.26 Deficit Reduction Act of 2005, Public Law
364.27 109-171.

364.28 (b) Contingent upon (1) publication by the
364.29 federal Centers for Medicare and Medicaid
364.30 Services of final regulations implementing
364.31 the targeted case management provisions
364.32 of the federal Deficit Reduction Act of
364.33 2005, Public Law 109-171, or (2) the
364.34 issuance of a finding by the Centers for
364.35 Medicare and Medicaid Services of federal

365.1 Medicaid overpayments for targeted case
365.2 management expenditures, up to $32,667,000
365.3 is appropriated to the commissioner of human
365.4 services. Prior to distribution of funds, the
365.5 commissioner shall estimate and certify the
365.6 amount by which the federal regulations or
365.7 federal disallowance will reduce targeted
365.8 case management Medicaid revenue over the
365.9 2008-2009 biennium.

365.10 (c) Within 60 days of a contingency described
365.11 in paragraph (b), the commissioner shall
365.12 distribute the grants proportionate to each
365.13 affected county or tribe's targeted case
365.14 management federal earnings for calendar
365.15 year 2005, not to exceed the lower of (1) the
365.16 amount of the estimated reduction in federal
365.17 revenue or (2) $32,667,000.

365.18 (d) These funds are available in either year of
365.19 the biennium. Counties and tribes shall use
365.20 these funds to pay for social service-related
365.21 costs, but the funds are not subject to
365.22 provisions of the Children and Community
365.23 Services Act grant under Minnesota Statutes,
365.24 chapter 256M.

365.25 (e) This appropriation shall be available to
365.26 pay counties and tribes for expenses incurred
365.27 on or after July 1, 2007. The appropriation
365.28 shall be available until expended.

365.29 (i) **General Assistance Grants**

365.30 General 37,876,000 38,253,000

365.31 **General Assistance Standard.** The
365.32 commissioner shall set the monthly standard
365.33 of assistance for general assistance units
365.34 consisting of an adult recipient who is
365.35 childless and unmarried or living apart

366.1 from parents or a legal guardian at $203.
366.2 The commissioner may reduce this amount
366.3 according to Laws 1997, chapter 85, article
366.4 3, section 54.

366.5 **Emergency General Assistance.** The
366.6 amount appropriated for emergency general
366.7 assistance funds is limited to no more
366.8 than $7,889,812 in fiscal year 2008 and
366.9 $7,889,812 in fiscal year 2009. Funds
366.10 to counties must be allocated by the
366.11 commissioner using the allocation method
366.12 specified in Minnesota Statutes, section
366.13 256D.06.

366.14 (j) **Minnesota Supplemental Aid Grants**

366.15 General 30,505,000 30,812,000

366.16 **Emergency Minnesota Supplemental**
366.17 **Aid Funds.** The amount appropriated for
366.18 emergency Minnesota supplemental aid
366.19 funds is limited to no more than $1,100,000
366.20 in fiscal year 2008 and $1,100,000 in fiscal
366.21 year 2009. Funds to counties must be
366.22 allocated by the commissioner using the
366.23 allocation method specified in Minnesota
366.24 Statutes, section 256D.46.

366.25 (k) **Group Residential Housing Grants**

366.26 General 91,069,000 98,671,000

366.27 **People Incorporated.** Of the general fund
366.28 appropriation, $460,000 each year is to
366.29 augment community support and mental
366.30 health services provided to individuals
366.31 residing in facilities under Minnesota
366.32 Statutes, section 256I.05, subdivision 1m.

366.33 (l) **Other Children and Economic Assistance**
366.34 **Grants**

367.1 General 20,183,000 16,333,000
367.2 Federal TANF 1,500,000 1,500,000

367.3 **Base Adjustment.** The general fund base
367.4 shall be $16,033,000 in fiscal year 2010 and
367.5 $15,533,000 in fiscal year 2011. The TANF
367.6 base shall be $1,500,000 in fiscal year 2010
367.7 and $1,181,000 in fiscal year 2011.

367.8 **Homeless and Runaway Youth.** Of the
367.9 general fund appropriation, $500,000 each
367.10 year are for the Runaway and Homeless
367.11 Youth Act under Minnesota Statutes, section
367.12 256K.45. Funds shall be spent in each area
367.13 of the continuum of care to ensure that
367.14 programs are meeting the greatest need. This
367.15 is a onetime appropriation.

367.16 **Long-Term Homelessness.** Of the general
367.17 fund appropriation, $2,000,000 in fiscal year
367.18 2008 is for implementation of programs
367.19 to address long-term homelessness and is
367.20 available in either year of the biennium. This
367.21 is a onetime appropriation.

367.22 **Minnesota Community Action Grants.** (a)
367.23 Of the general fund appropriation, $250,000
367.24 each year is for the purposes of Minnesota
367.25 community action grants under Minnesota
367.26 Statutes, sections 256E.30 to 256E.32. This
367.27 is a onetime appropriation.

367.28 (b) Of the TANF appropriation, $1,500,000
367.29 each year is for community action agencies
367.30 for auto repairs, auto loans, and auto
367.31 purchase grants to individuals who are
367.32 eligible to receive benefits under Minnesota
367.33 Statutes, chapter 256J, or who have lost
367.34 eligibility for benefits under Minnesota
367.35 Statutes, chapter 256J, due to earnings in the

368.1 prior 12 months. Base level funding for this
368.2 activity shall be $1,500,000 in fiscal year
368.3 2010 and $1,181,000 in fiscal year 2011. *
368.4 **(The preceding text beginning "(b) Of the**
368.5 **TANF appropriation," was indicated as**
368.6 **vetoed by the governor.)**

368.7 (c) Money appropriated under paragraphs (a)
368.8 and (b) that is not spent in the first year does
368.9 not cancel but is available for the second
368.10 year.

368.11 **EFFECTIVE DATE.** This section is effective the day following final enactment.

368.12 Sec. 13. **FEDERAL STIMULUS FUNDS; REPORT.**

368.13 By February 15, 2010, the commissioner of health shall submit to the chairs and
368.14 ranking minority members of the house of representatives and senate committees with
368.15 jurisdiction over public health and public safety finance a report on how funds from the
368.16 American Recovery and Reinvestment Act of 2009 are used: (1) to support advancing
368.17 the objectives of the Minnesota Department of Health's Sexual Violence Prevention Plan;
368.18 and (2) to support any pilot programs that might demonstrate and evaluate how use of
368.19 community-based prevention grants might serve as a model for future investment of state
368.20 resources to help advance the department's Sexual Violence Prevention Plan.

368.21 Sec. 14. **EMERGENCY SERVICES SHELTER GRANTS FROM AMERICAN**
368.22 **RECOVERY AND REINVESTMENT ACT.**

368.23 To the extent permitted under federal law, the commissioner of human services, when
368.24 determining the uses of the emergency services shelter grants provided under the American
368.25 Recovery and Reinvestment Act, shall give priority to programs that serve the following:
368.26 (1) homeless youth;
368.27 (2) American Indian women who are victims of trafficking;
368.28 (3) high-risk adult males considered to be very likely to enter or reenter state or
368.29 county correctional programs, or chemical and mental health programs;
368.30 (4) battered women; and
368.31 (5) families affected by foreclosure.

368.32 Sec. 15. **TRANSFERS.**

369.1 Subdivision 1. **Grants.** The commissioner of human services, with the approval
369.2 of the commissioner of finance, and after notification of the chairs of the relevant senate
369.3 budget division and house of representatives finance division committee, may transfer
369.4 unencumbered appropriation balances for the biennium ending June 30, 2011, within
369.5 fiscal years among the MFIP, general assistance, general assistance medical care, medical
369.6 assistance, MinnesotaCare, MFIP child care assistance under Minnesota Statutes, section
369.7 119B.05, Minnesota supplemental aid, and group residential housing programs, and the
369.8 entitlement portion of the chemical dependency consolidated treatment fund, and between
369.9 fiscal years of the biennium.

369.10 Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative
369.11 money may be transferred within the Departments of Human Services and Health as the
369.12 commissioners consider necessary, with the advance approval of the commissioner of
369.13 finance. The commissioner shall inform the chairs of the relevant house and senate health
369.14 committees quarterly about transfers made under this provision.

369.15 Sec. 16. **EXPIRATION OF UNCODIFIED LANGUAGE.**

369.16 All uncodified language contained in this article expires on June 30, 2011, unless a
369.17 different expiration date is explicit.

369.18 Sec. 17. **EFFECTIVE DATE.**

369.19 The provisions in this article are effective July 1, 2009, unless a different effective
369.20 date is specified.

APPENDIX

Article locations in h1362-2

ARTICLE 1	LICENSING	Page.Ln 2.47
ARTICLE 2	MFIP, CHILDREN, AND ADULT SUPPORTS	Page.Ln 23.13
ARTICLE 3	CHILD SUPPORT	Page.Ln 41.1
ARTICLE 4	STATE-OPERATED SERVICES	Page.Ln 43.1
ARTICLE 5	DEPARTMENT OF HEALTH AND HEALTH CARE	Page.Ln 48.4
ARTICLE 6	HEALTH CARE PROGRAMS	Page.Ln 66.22
ARTICLE 7	TECHNICAL	Page.Ln 137.20
ARTICLE 8	CHEMICAL AND MENTAL HEALTH	Page.Ln 155.30
ARTICLE 9	CONTINUING CARE	Page.Ln 166.10
ARTICLE 10	STATE-COUNTY RESULTS, ACCOUNTABILITY, AND SERVICE DELIVERY REFORM ACT	Page.Ln 272.18
ARTICLE 11	PUBLIC HEALTH	Page.Ln 280.24
ARTICLE 12	HEALTH-RELATED FEES	Page.Ln 313.29
ARTICLE 13	MISCELLANEOUS	Page.Ln 319.19
ARTICLE 14	HUMAN SERVICES FORECAST ADJUSTMENTS	Page.Ln 322.29
ARTICLE 15	APPROPRIATIONS	Page.Ln 324.19

62U.08 ESSENTIAL BENEFIT SET.

Subdivision 1. **Work group created.** The commissioner of health shall convene a work group to make recommendations on the design of a health benefit set that provides coverage for a broad range of services and technologies, is based on scientific evidence that the services and technologies are clinically effective and cost-effective, and provides lower enrollee cost sharing for services and technologies that have been determined to be cost-effective. The work group shall include representatives of health care providers, health plans, state agencies, and employers. Members of the work group must have expertise in standards for evidence-based care, benefit design and development, actuarial analysis, or knowledge relating to the analysis of the cost impact of coverage of specified benefits. The work group must meet at least once per year and at other times as necessary to make recommendations to the commissioner on updating the benefit set as necessary to ensure that the benefit set continues to be safe, effective, and scientifically based.

Subd. 2. **Duties.** By October 15, 2009, the work group shall develop and submit to the commissioner an initial essential benefit set and design that includes coverage for a broad range of services, is based on scientific evidence that services are clinically effective and cost-effective, and provides lower enrollee cost sharing for services that have been determined to be cost-effective. The benefit set must include necessary evidence-based health care services, procedures, diagnostic tests, and technologies that are scientifically proven to be both clinically effective and cost-effective. In developing its recommendations, the work group may consult with the Institute for Clinical Systems Improvement (ICSI) to assemble existing scientifically based practice standards.

Subd. 3. **Report.** By January 15, 2010, the commissioner shall report the recommendations of the work group to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health care policy and finance.

103I.112 FEE EXEMPTIONS FOR STATE AND LOCAL GOVERNMENT.

(a) The commissioner of health may not charge fees required under this chapter to a federal agency, state agency, or a local unit of government or to a subcontractor performing work for the state agency or local unit of government.

(b) "Local unit of government" means a statutory or home rule charter city, town, county, or soil and water conservation district, watershed district, an organization formed for the joint exercise of powers under section 471.59, a board of health or community health board, or other special purpose district or authority with local jurisdiction in water and related land resources management.

144.9501 DEFINITIONS.

Subd. 17b. **Lead interim control worker.** "Lead interim control worker" means an individual who is trained as specified by the commissioner to conduct interim control activities.

148D.180 FEE AMOUNTS.

Subd. 8. **Temporary fee reduction.** For fiscal years 2006, 2007, 2008, and 2009, the following fee changes are effective:

(1) in subdivision 1, the application fee for a licensed independent social worker is reduced to $45;

(2) in subdivision 1, the application fee for a licensed independent clinical social worker is reduced to $45;

(3) in subdivision 1, the application fee for a licensure by endorsement is reduced to $85;

(4) in subdivision 2, the license fee for a licensed social worker is reduced to $90;

(5) in subdivision 2, the license fee for a licensed graduate social worker is reduced to $160;

(6) in subdivision 2, the license fee for a licensed independent social worker is reduced to $240;

(7) in subdivision 2, the license fee for a licensed independent clinical social worker is reduced to $265;

(8) in subdivision 3, the renewal fee for a licensed social worker is reduced to $90;

(9) in subdivision 3, the renewal fee for a licensed graduate social worker is reduced to $160;

(10) in subdivision 3, the renewal fee for a licensed independent social worker is reduced to $240;

(11) in subdivision 3, the renewal fee for a licensed independent clinical social worker is reduced to $265; and

(12) in subdivision 5, the renewal late fee is reduced to one-third of the renewal fee specified in subdivision 3.

This subdivision expires on June 30, 2009.

246.51 PAYMENT FOR CARE AND TREATMENT; DETERMINATION.

Subdivision 1. **Procedures.** The commissioner shall make investigation as necessary to determine, and as circumstances require redetermine, what part of the cost of care, if any, the client is able to pay. If the client is unable to pay the full cost of care the commissioner shall make a determination as to the ability of the relatives to pay. The client and relatives shall provide the commissioner documents and proofs necessary to determine their ability to pay. Failure to provide the commissioner with sufficient information to determine ability to pay may make the client or relatives liable for the full cost of care until the time when sufficient information is provided. No parent shall be liable for the cost of care given a client at a regional treatment center after the client has reached the age of 18 years. The commissioner's determination shall be conclusive in any action to enforce payment of the cost of care unless appealed from as provided in section 246.55. All money received, except for chemical dependency receipts, shall be paid to the commissioner of finance and placed in the general fund of the state and a separate account kept of it. Except for services provided under chapter 254B, responsibility under this section shall not apply to those relatives having gross earnings of less than $11,000 per year.

246.53 CLAIM AGAINST ESTATE OF DECEASED CLIENT.

Subd. 3. **Exception from statute of limitations.** Any statute of limitations which limits the commissioner in recovering the cost of care obligation incurred by a client or former client shall not apply to any claim against an estate made hereunder to recover cost of care.

256.962 MINNESOTA HEALTH CARE PROGRAMS OUTREACH.

Subd. 7. **Renewal notice.** (a) Beginning December 1, 2007, the commissioner shall mail a renewal notice to enrollees notifying the enrollees that the enrollees eligibility must be renewed. A notice shall be sent at least 90 days prior to the renewal date and at least 60 days prior to the renewal date.

(b) For enrollees who are receiving services through managed care plans, the managed care plan must provide a follow-up renewal call at least 60 days prior to the enrollees' renewal dates.

(c) The commissioner shall include the end of coverage dates on the monthly rosters of enrollees provided to managed care organizations.

256B.0655 PERSONAL CARE ASSISTANT SERVICES.

Subdivision 1. **Definitions.** For purposes of this section and sections 256B.0651, 256B.0653, 256B.0654, and 256B.0656, the terms defined in subdivisions 1a to 1i have the meanings given them unless otherwise provided or indicated by the context.

Subd. 1a. **Activities of daily living.** "Activities of daily living" includes eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning.

Subd. 1c. **Care plan.** "Care plan" means a written description of personal care assistant services developed by the qualified professional or the recipient's physician with the recipient or responsible party to be used by the personal care assistant with a copy provided to the recipient or responsible party.

Subd. 1d. **Health-related functions.** "Health-related functions" means functions that can be delegated or assigned by a licensed health care professional under state law to be performed by a personal care assistant.

Subd. 1e. **Instrumental activities of daily living.** "Instrumental activities of daily living" includes meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communication by telephone and other media, and getting around and participating in the community.

Subd. 1f. **Personal care assistant.** (a) "Personal care assistant" means a person who:

(1) is at least 18 years old, except for persons 16 to 18 years of age who participated in a related school-based job training program or have completed a certified home health aide competency evaluation;

(2) is able to effectively communicate with the recipient and personal care provider organization;

(3) effective July 1, 1996, has completed one of the training requirements as specified in paragraph (b);

(4) has the ability to, and provides covered personal care assistant services according to the recipient's care plan, responds appropriately to recipient needs, and reports changes in the recipient's condition to the supervising qualified professional or physician;

(5) is not a consumer of personal care assistant services;

(6) maintains daily written records detailing:

(i) the actual services provided to the recipient; and

(ii) the amount of time spent providing the services; and

(7) is subject to criminal background checks and procedures specified in chapter 245C.

(b) Personal care assistant training must include successful completion of one or more training requirements in:

(1) a nursing assistant training program or its equivalent for which competency as a nursing assistant is determined according to a test administered by the Minnesota State Board of Technical Colleges;

(2) a homemaker home health aide preservice training program using a curriculum recommended by the Department of Health;

(3) an accredited educational program for registered nurses or licensed practical nurses;

(4) a training program that provides the assistant with skills required to perform personal care assistant services specified in subdivision 2; or

(5) a determination by the personal care provider that the assistant has, through training or experience, the skills required to perform the personal care services specified in subdivision 2.

Subd. 1g. **Personal care provider organization.** "Personal care provider organization" means an organization enrolled to provide personal care assistant services under the medical assistance program that complies with the following:

(1) owners who have a five percent interest or more, and managerial officials are subject to a background study as provided in chapter 245C. This applies to currently enrolled personal care provider organizations and those agencies seeking enrollment as a personal care provider organization. An organization will be barred from enrollment if an owner or managerial official of the organization has been convicted of a crime specified in chapter 245C, or a comparable crime in another jurisdiction, unless the owner or managerial official meets the reconsideration criteria specified in chapter 245C;

(2) the organization must maintain a surety bond and liability insurance throughout the duration of enrollment and provides proof thereof. The insurer must notify the Department of Human Services of the cancellation or lapse of policy and the organization must maintain documentation of services as specified in Minnesota Rules, part 9505.2175, subpart 7, as well as evidence of compliance with personal care assistant training requirements;

(3) the organization must maintain documentation and a recipient file and satisfy communication requirements in section 256B.0655, subdivision 2, paragraph (f); and

(4) the organization must comply with all laws and rules governing the provision of personal care assistant services.

Subd. 1h. **Responsible party.** "Responsible party" means an individual who is capable of providing the support necessary to assist the recipient to live in the community, is at least 18 years old, actively participates in planning and directing of personal care assistant services, and is not the personal care assistant. The responsible party must be accessible to the recipient and the personal care assistant when personal care services are being provided and monitor the services at least weekly according to the plan of care. The responsible party must be identified at the time of assessment and listed on the recipient's service agreement and care plan. Responsible parties who are parents of minors or guardians of minors or incapacitated persons may delegate the responsibility to another adult who is not the personal care assistant during a temporary absence of at least 24 hours but not more than six months. The person delegated as a responsible party must be able to meet the definition of responsible party, except that the delegated responsible party is required to reside with the recipient only while serving as the responsible party. The delegated responsible party is not required to reside with the recipient while serving as the responsible party if competent supervision to ensure the health and safety of the recipient and monitoring of services provided are stated as part of the person's individual service plan under a home care service or home and community-based waiver program or in conjunction with a home care targeted case

management service provider or other case manager. The responsible party must assure that the delegate performs the functions of the responsible party, is identified at the time of the assessment, and is listed on the service agreement and the care plan. Foster care license holders may be designated the responsible party for residents of the foster care home if case management is provided as required in section 256B.0625, subdivision 19a. For persons who, as of April 1, 1992, are sharing personal care assistant services in order to obtain the availability of 24-hour coverage, an employee of the personal care provider organization may be designated as the responsible party if case management is provided as required in section 256B.0625, subdivision 19a.

Subd. 1i. **Service plan.** "Service plan" means a written description of the services needed based on the assessment developed by the nurse who conducts the assessment together with the recipient or responsible party. The service plan shall include a description of the covered home care services, frequency and duration of services, and expected outcomes and goals. The recipient and the provider chosen by the recipient or responsible party must be given a copy of the completed service plan within 30 calendar days of the request for home care services by the recipient or responsible party.

Subd. 2. **Personal care assistant services.** (a) The personal care assistant services that are eligible for payment are services and supports furnished to an individual, as needed, to assist in accomplishing activities of daily living; instrumental activities of daily living; health-related functions through hands-on assistance, supervision, and cuing; and redirection and intervention for behavior including observation and monitoring.

(b) Payment for services will be made within the limits approved using the prior authorized process established in subdivisions 3 and 4, and sections 256B.0651, subdivisions 4 to 12, and 256B.0654, subdivision 2.

(c) The amount and type of services authorized shall be based on an assessment of the recipient's needs in these areas:

(1) bowel and bladder care;

(2) skin care to maintain the health of the skin;

(3) repetitive maintenance range of motion, muscle strengthening exercises, and other tasks specific to maintaining a recipient's optimal level of function;

(4) respiratory assistance;

(5) transfers and ambulation;

(6) bathing, grooming, and hair washing necessary for personal hygiene;

(7) turning and positioning;

(8) assistance with furnishing medication that is self-administered;

(9) application and maintenance of prosthetics and orthotics;

(10) cleaning medical equipment;

(11) dressing or undressing;

(12) assistance with eating and meal preparation and necessary grocery shopping;

(13) accompanying a recipient to obtain medical diagnosis or treatment;

(14) assisting, monitoring, or prompting the recipient to complete the services in clauses (1) to (13);

(15) redirection, monitoring, and observation that are medically necessary and an integral part of completing the personal care assistant services described in clauses (1) to (14);

(16) redirection and intervention for behavior, including observation and monitoring;

(17) interventions for seizure disorders, including monitoring and observation if the recipient has had a seizure that requires intervention within the past three months;

(18) tracheostomy suctioning using a clean procedure if the procedure is properly delegated by a registered nurse. Before this procedure can be delegated to a personal care assistant, a registered nurse must determine that the tracheostomy suctioning can be accomplished utilizing a clean rather than a sterile procedure and must ensure that the personal care assistant has been taught the proper procedure; and

(19) incidental household services that are an integral part of a personal care service described in clauses (1) to (18).

For purposes of this subdivision, monitoring and observation means watching for outward visible signs that are likely to occur and for which there is a covered personal care service or an appropriate personal care intervention. For purposes of this subdivision, a clean procedure refers to a procedure that reduces the numbers of microorganisms or prevents or reduces the transmission of microorganisms from one person or place to another. A clean procedure may be used beginning 14 days after insertion.

(d) The personal care assistant services that are not eligible for payment are the following:

(1) services provided without a physician's statement of need as required by section 256B.0625, subdivision 19c, and included in the personal care provider agency's file for the recipient;

(2) assessments by personal care assistant provider organizations or by independently enrolled registered nurses;

(3) services that are not in the service plan;

(4) services provided by the recipient's spouse, legal guardian for an adult or child recipient, or parent of a recipient under age 18;

(5) services provided by a foster care provider of a recipient who cannot direct the recipient's own care, unless monitored by a county or state case manager under section 256B.0625, subdivision 19a;

(6) services provided by the residential or program license holder in a residence for more than four persons;

(7) services that are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules;

(8) sterile procedures;

(9) injections of fluids into veins, muscles, or skin;

(10) homemaker services that are not an integral part of a personal care assistant services;

(11) home maintenance or chore services;

(12) services not specified under paragraph (a); and

(13) services not authorized by the commissioner or the commissioner's designee.

(e) The recipient or responsible party may choose to supervise the personal care assistant or to have a qualified professional, as defined in section 256B.0625, subdivision 19c, provide the supervision. As required under section 256B.0625, subdivision 19c, the county public health nurse, as a part of the assessment, will assist the recipient or responsible party to identify the most appropriate person to provide supervision of the personal care assistant. Health-related delegated tasks performed by the personal care assistant will be under the supervision of a qualified professional or the direction of the recipient's physician. If the recipient has a qualified professional, Minnesota Rules, part 9505.0335, subpart 4, applies.

(f) In order to be paid for personal care assistant services, personal care provider organizations, and personal care assistant choice providers are required:

(1) to maintain a recipient file for each recipient for whom services are being billed that contains:

(i) the current physician's statement of need as required by section 256B.0625, subdivision 19c;

(ii) the service plan, including the monthly authorized hours, or flexible use plan;

(iii) the care plan, signed by the recipient and the qualified professional, if required or designated, detailing the personal care assistant services to be provided;

(iv) documentation, on a form approved by the commissioner and signed by the personal care assistant, specifying the day, month, year, arrival, and departure times, with AM and PM notation, for all services provided to the recipient. The form must include a notice that it is a federal crime to provide false information on personal care service billings for medical assistance payment; and

(v) all notices to the recipient regarding personal care service use exceeding authorized hours; and

(2) to communicate, by telephone if available, and in writing, with the recipient or the responsible party about the schedule for use of authorized hours and to notify the recipient and the county public health nurse in advance and as soon as possible, on a form approved by the commissioner, if the monthly number of hours authorized is likely to be exceeded for the month.

(g) The commissioner shall establish an ongoing audit process for potential fraud and abuse for personal care assistant services. The audit process must include, at a minimum, a requirement that the documentation of hours of care provided be on a form approved by the commissioner and include the personal care assistant's signature attesting that the hours shown on each bill were provided by the personal care assistant on the dates and the times specified.

Subd. 3. **Assessment and service plan.** Assessments under subdivision 1b and sections 256B.0651, subdivision 1, paragraph (b), and 256B.0654, subdivision 1, paragraph (a), shall be conducted initially, and at least annually thereafter, in person with the recipient and result in a completed service plan using forms specified by the commissioner. A personal care provider agency must use a form approved by the commissioner to request a county public health nurse to conduct a personal care assistant services assessment. When requesting a reassessment, the personal care provider agency must notify the county and the recipient at least 60 days prior to the end of the current prior authorization for personal care assistant services. The recipient

notice shall include information on the recipient's appeal rights. Within 30 days of recipient or responsible party or personal care assistant provider agency request for home care services, the assessment, the service plan, and other information necessary to determine medical necessity such as diagnostic or testing information, social or medical histories, and hospital or facility discharge summaries shall be submitted to the commissioner. Notwithstanding the provisions of subdivision 8, the commissioner shall maximize federal financial participation to pay for public health nurse assessments for personal care services. For personal care assistant services:

(1) The amount and type of service authorized based upon the assessment and service plan will follow the recipient if the recipient chooses to change providers.

(2) If the recipient's need changes, the recipient's provider may assess the need for a change in service authorization and request the change from the county public health nurse. The request must be made on a form approved by the commissioner. Within 30 days of the request, the public health nurse will determine whether to request the change in services based upon the provider assessment, or conduct a home visit to assess the need and determine whether the change is appropriate. If the change in service need is due to a change in medical condition, a new physician's statement of need required by section 256B.0625, subdivision 19c, must be obtained.

(3) To continue to receive personal care assistant services after the first year, the recipient or the responsible party, in conjunction with the public health nurse, may complete a service update on forms developed by the commissioner according to criteria and procedures in subdivisions 1a to 1i and sections 256B.0651, subdivision 1; 256B.0653; and 256B.0654, subdivision 1.

Subd. 5. **Shared personal care assistant services.** (a) Medical assistance payments for shared personal care assistance services shall be limited according to this subdivision.

(b) Recipients of personal care assistant services may share staff and the commissioner shall provide a rate system for shared personal care assistant services. For two persons sharing services, the rate paid to a provider shall not exceed 1-1/2 times the rate paid for serving a single individual, and for three persons sharing services, the rate paid to a provider shall not exceed twice the rate paid for serving a single individual. These rates apply only to situations in which all recipients were present and received shared services on the date for which the service is billed. No more than three persons may receive shared services from a personal care assistant in a single setting.

(c) Shared service is the provision of personal care assistant services by a personal care assistant to two or three recipients at the same time and in the same setting. For the purposes of this subdivision, "setting" means:

(1) the home or foster care home of one of the individual recipients; or

(2) a child care program in which all recipients served by one personal care assistant are participating, which is licensed under chapter 245A or operated by a local school district or private school; or

(3) outside the home or foster care home of one of the recipients when normal life activities take the recipients outside the home.

The provisions of this subdivision do not apply when a personal care assistant is caring for multiple recipients in more than one setting.

(d) The recipient or the recipient's responsible party, in conjunction with the county public health nurse, shall determine:

(1) whether shared personal care assistant services is an appropriate option based on the individual needs and preferences of the recipient; and

(2) the amount of shared services allocated as part of the overall authorization of personal care assistant services.

The recipient or the responsible party, in conjunction with the supervising qualified professional, if a qualified professional is requested by any one of the recipients or responsible parties, shall arrange the setting and grouping of shared services based on the individual needs and preferences of the recipients. Decisions on the selection of recipients to share services must be based on the ages of the recipients, compatibility, and coordination of their care needs.

(e) The following items must be considered by the recipient or the responsible party and the supervising qualified professional, if a qualified professional has been requested by any one of the recipients or responsible parties, and documented in the recipient's health service record:

(1) the additional qualifications needed by the personal care assistant to provide care to several recipients in the same setting;

(2) the additional training and supervision needed by the personal care assistant to ensure that the needs of the recipient are met appropriately and safely. The provider must provide on-site supervision by a qualified professional within the first 14 days of shared services, and monthly thereafter, if supervision by a qualified provider has been requested by any one of the recipients or responsible parties;

(3) the setting in which the shared services will be provided;

(4) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting; and

(5) a contingency plan which accounts for absence of the recipient in a shared services setting due to illness or other circumstances and staffing contingencies.

(f) The provider must offer the recipient or the responsible party the option of shared or one-on-one personal care assistant services. The recipient or the responsible party can withdraw from participating in a shared services arrangement at any time.

(g) In addition to documentation requirements under Minnesota Rules, part 9505.2175, a personal care provider must meet documentation requirements for shared personal care assistant services and must document the following in the health service record for each individual recipient sharing services:

(1) permission by the recipient or the recipient's responsible party, if any, for the maximum number of shared services hours per week chosen by the recipient;

(2) permission by the recipient or the recipient's responsible party, if any, for personal care assistant services provided outside the recipient's residence;

(3) permission by the recipient or the recipient's responsible party, if any, for others to receive shared services in the recipient's residence;

(4) revocation by the recipient or the recipient's responsible party, if any, of the shared service authorization, or the shared service to be provided to others in the recipient's residence, or the shared service to be provided outside the recipient's residence;

(5) supervision of the shared personal care assistant services by the qualified professional, if a qualified professional is requested by one of the recipients or responsible parties, including the date, time of day, number of hours spent supervising the provision of shared services, whether the supervision was face-to-face or another method of supervision, changes in the recipient's condition, shared services scheduling issues and recommendations;

(6) documentation by the qualified professional, if a qualified professional is requested by one of the recipients or responsible parties, of telephone calls or other discussions with the personal care assistant regarding services being provided to the recipient who has requested the supervision; and

(7) daily documentation of the shared services provided by each identified personal care assistant including:

(i) the names of each recipient receiving shared services together;

(ii) the setting for the shared services, including the starting and ending times that the recipient received shared services; and

(iii) notes by the personal care assistant regarding changes in the recipient's condition, problems that may arise from the sharing of services, scheduling issues, care issues, and other notes as required by the qualified professional, if a qualified professional is requested by one of the recipients or responsible parties.

(h) Unless otherwise provided in this subdivision, all other statutory and regulatory provisions relating to personal care assistant services apply to shared services.

(i) In the event that supervision by a qualified professional has been requested by one or more recipients, but not by all of the recipients, the supervision duties of the qualified professional shall be limited to only those recipients who have requested the supervision.

Nothing in this subdivision shall be construed to reduce the total number of hours authorized for an individual recipient.

Subd. 6. **Flexible use option.** (a) "Flexible use option" means the scheduled use of authorized hours of personal care assistant services, which vary within a service authorization period covering no more than six months, in order to more effectively meet the needs and schedule of the recipient. Authorized hours not used within the six-month period may not be carried over to another time period. The flexible use of personal care assistant hours for a six-month period must be prior authorized by the commissioner, based on a request submitted on a form approved by the commissioner. The request must include the assessment and the annual service plan prepared by the county public health nurse.

(b) The recipient or responsible party, together with the case manager, if the recipient has case management services, and the county public health nurse, shall determine whether flexible use is an appropriate option based on the needs, abilities, preferences, and history of service use of the recipient or responsible party, and if appropriate, must ensure that the allocation of hours covers the ongoing needs of the recipient over an entire year divided into two six-month periods of flexible use. A recipient who has terminated personal care assistant services before the end of the 12-month authorization period shall not receive additional hours upon reapplying during the same

12-month authorization period, except if a change in condition is documented. Services shall be prorated for the remainder of the 12-month authorization period based on earlier assessment.

(c) If prior authorized, recipients may use their approved hours flexibly within the service authorization period for medically necessary covered services specified in the assessment required in subdivision 1b and section 256B.0651, subdivision 1, paragraph (b). The flexible use of authorized hours does not increase the total amount of authorized hours available to a recipient as determined under subdivision 4. The commissioner shall not authorize additional personal care assistant services to supplement a service authorization that is exhausted before the end date under a flexible service use plan, unless the county public health nurse determines a change in condition and a need for increased services is established.

(d) The personal care provider organization and the recipient or responsible party or the personal care assistance choice provider must develop a written month-to-month plan of the projected use of personal care assistant services that is part of the care plan and ensures:

(1) that the health and safety needs of the recipient will be met;

(2) that the total annual authorization will not be used before the end of the authorization period; and

(3) monthly monitoring will be conducted of hours used as a percentage of the authorized amount.

(e) The provider shall notify the recipient or responsible party, any case manager for the recipient, and the county public health nurse in advance and as soon as possible, on a form approved by the commissioner, if the monthly amount of hours authorized is likely to be exceeded for the month.

(f) The commissioner shall provide written notice to the provider, the recipient or responsible party, any case manager for the recipient, and the county public health nurse, when a flexible use recipient exceeds the personal care assistant service authorization for the month by an amount determined by the commissioner. If the use of hours exceeds the monthly service authorization by the amount determined by the commissioner for two months during any three-month period, the commissioner shall notify the recipient and the county public health nurse that the flexible use authorization will be revoked beginning the following month. The revocation will not become effective if, within ten working days of the commissioner's notice of flexible use revocation, the county public health nurse requests prior authorization for an increase in the service authorization or continuation of the flexible use option, or the recipient appeals and assistance pending appeal is ordered. The commissioner shall determine whether to approve the increase and continued flexible use.

(g) The recipient or responsible party may stop the flexible use of hours by notifying the personal care provider organization or the personal care assistance choice provider and county public health nurse in writing.

(h) The recipient or responsible party may appeal the commissioner's action according to section 256.045. The denial or revocation of the flexible use option shall not affect the recipient's authorized level of personal care assistant services as determined under subdivision 4.

Subd. 7. **Fiscal intermediary option.** (a) The commissioner may allow a recipient of personal care assistant services to use a fiscal intermediary to assist the recipient in paying and accounting for medically necessary covered personal care assistant services authorized in subdivision 2 and within the payment parameters of subdivision 4. Unless otherwise provided in this subdivision, all other statutory and regulatory provisions relating to personal care assistant services apply to a recipient using the fiscal intermediary option.

(b) The recipient or responsible party shall:

(1) recruit, hire, and terminate a qualified professional, if a qualified professional is requested by the recipient or responsible party;

(2) verify and document the credentials of the qualified professional, if a qualified professional is requested by the recipient or responsible party;

(3) develop a service plan based on physician orders and public health nurse assessment with the assistance of a qualified professional, if a qualified professional is requested by the recipient or responsible party, that addresses the health and safety of the recipient;

(4) recruit, hire, and terminate the personal care assistant;

(5) orient and train the personal care assistant with assistance as needed from the qualified professional;

(6) supervise and evaluate the personal care assistant with assistance as needed from the recipient's physician or the qualified professional;

(7) monitor and verify in writing and report to the fiscal intermediary the number of hours worked by the personal care assistant and the qualified professional; and

(8) enter into a written agreement, as specified in paragraph (f).

(c) The duties of the fiscal intermediary shall be to:

(1) bill the medical assistance program for personal care assistant and qualified professional services;

(2) request and secure background checks on personal care assistants and qualified professionals according to chapter 245C;

(3) pay the personal care assistant and qualified professional based on actual hours of services provided;

(4) withhold and pay all applicable federal and state taxes;

(5) verify and keep records of hours worked by the personal care assistant and qualified professional;

(6) make the arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;

(7) enroll in the medical assistance program as a fiscal intermediary; and

(8) enter into a written agreement as specified in paragraph (f) before services are provided.

(d) The fiscal intermediary:

(1) may not be related to the recipient, qualified professional, or the personal care assistant;

(2) must ensure arm's-length transactions with the recipient and personal care assistant; and

(3) shall be considered a joint employer of the personal care assistant and qualified professional to the extent specified in this section and sections 256B.0651, 256B.0653, 256B.0654, and 256B.0656.

The fiscal intermediary or owners of the entity that provides fiscal intermediary services under this subdivision must pass a criminal background check.

(e) If the recipient or responsible party requests a qualified professional, the qualified professional providing assistance to the recipient shall meet the qualifications specified in section 256B.0625, subdivision 19c. The qualified professional shall assist the recipient in developing and revising a plan to meet the recipient's needs, as assessed by the public health nurse. In performing this function, the qualified professional must visit the recipient in the recipient's home at least once annually. The qualified professional must report any suspected abuse, neglect, or financial exploitation of the recipient to the appropriate authorities.

(f) The fiscal intermediary, recipient or responsible party, personal care assistant, and qualified professional shall enter into a written agreement before services are started. The agreement shall include:

(1) the duties of the recipient, qualified professional, personal care assistant, and fiscal agent based on paragraphs (a) to (e);

(2) the salary and benefits for the personal care assistant and the qualified professional;

(3) the administrative fee of the fiscal intermediary and services paid for with that fee, including background check fees;

(4) procedures to respond to billing or payment complaints; and

(5) procedures for hiring and terminating the personal care assistant and the qualified professional.

(g) The rates paid for personal care assistant services, shared care services, qualified professional services, and fiscal intermediary services under this subdivision shall be the same rates paid for personal care assistant services and qualified professional services under section 256B.0651, subdivision 2, respectively. Except for the administrative fee of the fiscal intermediary specified in paragraph (f), the remainder of the rates paid to the fiscal intermediary must be used to pay for the salary and benefits for the personal care assistant or the qualified professional.

(h) As part of the assessment defined in subdivision 1b, the following conditions must be met to use or continue use of a fiscal intermediary:

(1) the recipient must be able to direct the recipient's own care, or the responsible party for the recipient must be readily available to direct the care of the personal care assistant;

(2) the recipient or responsible party must be knowledgeable of the health care needs of the recipient and be able to effectively communicate those needs;

(3) a face-to-face assessment must be conducted by the local county public health nurse at least annually, or when there is a significant change in the recipient's condition or change in the need for personal care assistant services;

(4) recipients who choose to use the shared care option as specified in subdivision 5 must utilize the same fiscal intermediary; and

(5) parties must be in compliance with the written agreement specified in paragraph (f).

(i) The commissioner shall deny, revoke, or suspend the authorization to use the fiscal intermediary option if:

(1) it has been determined by the qualified professional or local county public health nurse that the use of this option jeopardizes the recipient's health and safety;

(2) the parties have failed to comply with the written agreement specified in paragraph (f); or

(3) the use of the option has led to abusive or fraudulent billing for personal care assistant services.

The recipient or responsible party may appeal the commissioner's action according to section 256.045. The denial, revocation, or suspension to use the fiscal intermediary option shall not affect the recipient's authorized level of personal care assistant services as determined in subdivision 4.

Subd. 8. **Public health nurse assessment rate.** (a) The reimbursement rates for public health nurse visits that relate to the provision of personal care services under this section and section 256B.0625, subdivision 19a, are:

(1) $210.50 for a face-to-face assessment visit;

(2) $105.25 for each service update; and

(3) $105.25 for each request for a temporary service increase.

(b) The rates specified in paragraph (a) must be adjusted to reflect provider rate increases for personal care assistant services that are approved by the legislature for the fiscal year ending June 30, 2000, and subsequent fiscal years. Any requirements applied by the legislature to provider rate increases for personal care assistant services also apply to adjustments under this paragraph.

(c) Effective July 1, 2008, the payment rate for an assessment under this section and section 256B.0651 shall be reduced by 25 percent when the assessment is not completed on time or the service agreement documentation is not submitted in time to continue services. The commissioner shall recoup these amounts on a retroactive basis.

Subd. 9. **Quality assurance plan.** The commissioner shall establish a quality assurance plan for personal care assistant services that includes:

(1) performance-based provider agreements;

(2) meaningful consumer input, which may include consumer surveys, that measure the extent to which participants receive the services and supports described in the individual plan and participant satisfaction with such services and supports;

(3) ongoing monitoring of the health and well-being of consumers; and

(4) an ongoing public process for development, implementation, and review of the quality assurance plan.

Subd. 10. **Oversight of enrolled providers.** The commissioner may request from providers documentation of compliance with laws, rules, and policies governing the provision of personal care assistant services. A personal care assistant service provider must provide the requested documentation to the commissioner within ten business days of the request. Failure to provide information to demonstrate substantial compliance with laws, rules, or policies may result in suspension, denial, or termination of the provider agreement.

Subd. 11. **Personal care provider responsibilities.** The personal care provider shall:

(1) employ or contract with services staff to provide personal care services and to train services staff as necessary;

(2) supervise the personal care services as provided in subdivision 2, paragraph (f);

(3) employ a personal care assistant that a qualified recipient brings to the personal care provider as the recipient's choice of assistant and who meets the employment qualifications of the provider, except that a personal care provider who must comply with the requirements of a governmental personnel administration system is exempt from this clause;

(4) bill the medical assistance program for a personal care service by the personal care assistant and a visit by the qualified professional supervising the personal care assistant;

(5) establish a grievance mechanism to resolve consumer complaints about personal care services, including the personal care provider's decision whether to employ the qualified recipient's choice of a personal care assistant;

(6) keep records as required in Minnesota Rules, parts 9505.2160 to 9505.2195;

(7) perform functions and provide services specified in the personal care provider's contract;

(8) comply with applicable rules and statutes; and

(9) perform other functions as necessary to carry out the responsibilities in clauses (1) to (8).

Subd. 12. **Personal care provider; employment prohibition.** A personal care provider shall not employ a person to provide personal care service for a qualified recipient if the person:

(1) refuses to provide full disclosure of criminal history records as specified in Minnesota Rules, part 9505.0335, subpart 12;

(2) has been convicted of a crime that directly relates to the occupation of providing personal care services to a qualified recipient;

(3) has jeopardized the health or welfare of a vulnerable adult through physical abuse, sexual abuse, or neglect as defined in section 626.557; or

(4) is misusing or is dependent on mood-altering chemicals, including alcohol, to the extent that the personal care provider knows or has reason to believe that the use of chemicals has a negative effect on the person's ability to provide personal care services or the use of chemicals is apparent during the hours the person is providing personal care services.

Subd. 13. **Supervision of personal care services.** A personal care service to a qualified recipient as described in subdivision 4 shall be under the supervision of a qualified professional who shall have the following duties:

(1) ensure that the personal care assistant is capable of providing the required personal care services through direct observation of the assistant's work or through consultation with the qualified recipient;

(2) ensure that the personal care assistant is knowledgeable about the plan of personal care services before the personal care assistant performs personal care services;

(3) ensure that the personal care assistant is knowledgeable about essential observations of the recipient's health, and about any conditions that should be immediately brought to the attention of either the qualified professional or the attending physician;

(4) evaluate the personal care services of a recipient through direct observation of the personal care assistant's work or through consultation with the qualified recipient. Evaluation shall be made:

(i) within 14 days after the placement of a personal care assistant with the qualified recipient;

(ii) at least once every 30 days during the first 90 days after the qualified recipient first receives personal care services according to the plan of personal care service; and

(iii) at least once every 120 days following the period of evaluations in item (ii). The qualified professional shall record in writing the results of the evaluation and actions taken to correct any deficiencies in the work of the personal care assistant;

(5) review, together with the recipient, and revise, as necessary, the plan of personal care services at least once every 120 days after a plan of personal care services is developed;

(6) ensure that the personal care assistant and recipient are knowledgeable about a change in the plan of personal care services;

(7) ensure that records are kept, showing the services provided to the recipient by the personal care assistant as described in subdivision 2, paragraph (f), and the time spent providing the services;

(8) determine that a qualified recipient is still capable of directing the recipient's own care or has a responsible party; and

(9) determine with a physician that a recipient is a qualified recipient.

256B.071 MEDICARE MAXIMIZATION PROGRAM.

Subdivision 1. **Definition.** (a) "Dual entitlees" means recipients eligible for either the medical assistance program or the alternative care program who are also eligible for the federal Medicare program.

(b) For purposes of this section, "home care services" means home health agency services, private duty nursing services, personal care assistant services, waivered services, alternative care program services, hospice services, rehabilitation therapy services, and suppliers of medical supplies and equipment.

Subd. 2. **Technical assistance to providers.** (a) The commissioner shall establish a technical assistance program to require providers of services and equipment under this section to maximize collections from the federal Medicare program. The technical assistance may include the provision of materials to help providers determine those services and equipment likely to be reimbursed by Medicare.

(b) Any provider of home care services enrolled in the medical assistance program, or county public health nursing agency responsible for personal care assessments, or county case managers for alternative care or medical assistance waiver programs, is required to use the method developed and supplied by the Department of Human Services for determining Medicare coverage for home care equipment and services provided to dual entitlees to ensure appropriate billing of Medicare.

Subd. 3. **Referrals to Medicare providers required.** Non-Medicare certified home care providers and medical suppliers that do not participate or accept Medicare assignment must refer and document the referral of dual eligible recipients to Medicare providers when Medicare is

determined to be the appropriate payer for services and supplies and equipment. Providers will be terminated from participation in the medical assistance program for failure to make such referrals.

Subd. 4. **Medicare certification requirement.** Medicare certification is required of all medical assistance enrolled home care service providers as required under Title XIX of the Social Security Act.

256B.092 SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES.

Subd. 5a. **Increasing adult foster care capacity to serve five persons.** (a) When an adult foster care provider increases the capacity of an existing home licensed to serve four persons to serve a fifth person under this section, the county agency shall reduce the contracted per diem cost for room and board and the developmental disability waiver services of the existing foster care home by an average of 14 percent for all individuals living in that home. A county agency may average the required per diem rate reductions across several adult foster care homes that expand capacity under this section to achieve the necessary overall per diem reduction.

(b) Following the contract changes in paragraph (a), the commissioner shall adjust:

(1) individual county allocations for developmental disability waivered services by the amount of savings that results from the changes made for developmental disability waiver recipients for whom the county is financially responsible; and

(2) group residential housing rate payments to the adult foster care home by the amount of savings that results from the changes made.

(c) Effective July 1, 2003, when a new five-person adult foster care home is licensed under this section, county agencies shall not establish group residential housing room and board rates and developmental disability waiver service rates for the new home that exceed 86 percent of the average per diem room and board and developmental disability waiver services costs of four-person homes serving persons with comparable needs and in the same geographic area. A county agency developing more than one new five-person adult foster care home may average the required per diem rates across the homes to achieve the necessary overall per diem reductions.

(d) The commissioner shall reduce the individual county allocations for developmental disability waivered services by the savings resulting from the per diem limits on adult foster care recipients for whom the county is financially responsible, and shall limit the group residential housing rate for a new five-person adult foster care home.

256B.19 DIVISION OF COST.

Subd. 1d. **Portion of nonfederal share to be paid by certain counties.** (a) In addition to the percentage contribution paid by a county under subdivision 1, the governmental units designated in this subdivision shall be responsible for an additional portion of the nonfederal share of medical assistance cost. For purposes of this subdivision, "designated governmental unit" means the counties of Becker, Beltrami, Clearwater, Cook, Dodge, Hubbard, Itasca, Lake, Pennington, Pipestone, Ramsey, St. Louis, Steele, Todd, Traverse, and Wadena.

(b) Beginning in 1994, each of the governmental units designated in this subdivision shall transfer before noon on May 31 to the state Medicaid agency an amount equal to the number of licensed beds in any nursing home owned and operated by the county on that date, with the county named as licensee, multiplied by $5,723. If two or more counties own and operate a nursing home, the payment shall be prorated. These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs.

(c) Beginning in 2002, in addition to any transfer under paragraph (b), each of the governmental units designated in this subdivision shall transfer before noon on May 31 to the state Medicaid agency an amount equal to the number of licensed beds in any nursing home owned and operated by the county on that date, with the county named as licensee, multiplied by $10,784. The provisions of paragraph (b) apply to transfers under this paragraph.

(d) The commissioner may reduce the intergovernmental transfers under paragraph (c) based on the commissioner's determination of the payment rate in section 256B.431, subdivision 23, paragraphs (c) and (d). Any adjustments must be made on a per-bed basis and must result in an amount equivalent to the total amount resulting from the rate adjustment in section 256B.431, subdivision 23, paragraphs (c) and (d).

256B.431 RATE DETERMINATION.

Subd. 23. **County nursing home payment adjustments.** (a) Beginning in 1994, the commissioner shall pay a nursing home payment adjustment on May 31 after noon to a county in which is located a nursing home that, on that date, was county-owned and operated, with the

county named as licensee by the commissioner of health, and had over 40 beds and medical assistance occupancy in excess of 50 percent during the reporting year ending September 30, 1991. The adjustment shall be an amount equal to $16 per calendar day multiplied by the number of beds licensed in the facility on that date.

(b) Payments under paragraph (a) are excluded from medical assistance per diem rate calculations. These payments are required notwithstanding any rule prohibiting medical assistance payments from exceeding payments from private pay residents. A facility receiving a payment under paragraph (a) may not increase charges to private pay residents by an amount equivalent to the per diem amount payments under paragraph (a) would equal if converted to a per diem.

(c) Beginning in 2002, in addition to any payment under paragraph (a), the commissioner shall pay to a nursing facility described in paragraph (a) an adjustment in an amount equal to $29.55 per calendar day multiplied by the number of beds licensed in the facility on that date. The provisions of paragraphs (a) and (b) apply to payments under this paragraph.

(d) The commissioner may reduce payments under paragraph (c) based on the commissioner's determination of Medicare upper payment limits. Any adjustments must be proportional to adjustments made under section 256B.19, subdivision 1d, paragraph (d).

256D.46 EMERGENCY MINNESOTA SUPPLEMENTAL AID.

Subdivision 1. **Eligibility.** A county agency must grant emergency Minnesota supplemental aid, to the extent funds are available, if the recipient is without adequate resources to resolve an emergency that, if unresolved, will threaten the health or safety of the recipient. For the purposes of this section, the term "recipient" includes persons for whom a group residential housing benefit is being paid under sections 256I.01 to 256I.06.

Subd. 2. **Income and resource test.** All income and resources available to the recipient must be considered in determining the recipient's ability to meet the emergency need. Property that can be liquidated in time to resolve the emergency and income, excluding an amount equal to the Minnesota supplemental aid standard of assistance, that is normally disregarded or excluded under the Minnesota supplemental aid program must be considered available to meet the emergency need.

Subd. 3. **Payment amount.** The amount of assistance granted under emergency Minnesota supplemental aid is limited to the amount necessary to resolve the emergency. An emergency Minnesota supplemental aid grant is available to a recipient no more than once in any 12-month period. Funding for emergency Minnesota supplemental aid is limited to the appropriation. Each fiscal year, the commissioner shall allocate to counties the money appropriated for emergency Minnesota supplemental aid grants based on each county agency's average share of state's emergency Minnesota supplemental aid expenditures for the immediate past three fiscal years as determined by the commissioner, and may reallocate any unspent amounts to other counties. Any emergency Minnesota supplemental aid expenditures by a county above the amount of the commissioner's allocation to the county must be made from county funds.

256I.06 PAYMENT METHODS.

Subd. 9. **Community living adjustment.** Effective August 1, 2005, persons eligible for and residing in group residential housing under section 256I.04 shall receive a group residential housing community living adjustment of $12 per month.

256J.626 MFIP CONSOLIDATED FUND.

Subd. 7. **Performance base funds.** (a) For calendar year 2009 and yearly thereafter, each county and tribe will be allocated 95 percent of their initial calendar year allocation. Counties and tribes will be allocated additional funds based on performance as follows:

(1) a county or tribe that achieves a 50 percent TANF participation rate or a five percentage point improvement over the previous year's TANF participation rate under section 256J.751, subdivision 2, clause (7), as averaged across 12 consecutive months for the most recent year for which the measurements are available, will receive an additional allocation equal to 2.5 percent of its initial allocation; and

(2) a county or tribe that performs within or above its range of expected performance on the annualized three-year self-support index under section 256J.751, subdivision 2, clause (6), will receive an additional allocation equal to 2.5 percent of its initial allocation; and

(3) a county or tribe that does not achieve a 50 percent TANF participation rate or a five percentage point improvement over the previous year's TANF participation rate under section 256J.751, subdivision 2, clause (7), as averaged across 12 consecutive months for the most recent

year for which the measurements are available, will not receive an additional 2.5 percent of its initial allocation until after negotiating a multiyear improvement plan with the commissioner; or

(4) a county or tribe that does not perform within or above its range of expected performance on the annualized three-year self-support index under section 256J.751, subdivision 2, clause (6), will not receive an additional allocation equal to 2.5 percent of its initial allocation until after negotiating a multiyear improvement plan with the commissioner.

(b) For calendar year 2009 and yearly thereafter, performance-based funds for a federally approved tribal TANF program in which the state and tribe have in place a contract under section 256.01, addressing consolidated funding, will be allocated as follows:

(1) a tribe that achieves the participation rate approved in its federal TANF plan using the average of 12 consecutive months for the most recent year for which the measurements are available, will receive an additional allocation equal to 2.5 percent of its initial allocation; and

(2) a tribe that performs within or above its range of expected performance on the annualized three-year self-support index under section 256J.751, subdivision 2, clause (6), will receive an additional allocation equal to 2.5 percent of its initial allocation; or

(3) a tribe that does not achieve the participation rate approved in its federal TANF plan using the average of 12 consecutive months for the most recent year for which the measurements are available, will not receive an additional allocation equal to 2.5 percent of its initial allocation until after negotiating a multiyear improvement plan with the commissioner; or

(4) a tribe that does not perform within or above its range of expected performance on the annualized three-year self-support index under section 256J.751, subdivision 2, clause (6), will not receive an additional allocation equal to 2.5 percent until after negotiating a multiyear improvement plan with the commissioner.

(c) Funds remaining unallocated after the performance-based allocations in paragraph (a) are available to the commissioner for innovation projects under subdivision 5.

(d)(1) If available funds are insufficient to meet county and tribal allocations under paragraph (a), the commissioner may make available for allocation funds that are unobligated and available from the innovation projects through the end of the current biennium.

(2) If after the application of clause (1) funds remain insufficient to meet county and tribal allocations under paragraph (a), the commissioner must proportionally reduce the allocation of each county and tribe with respect to their maximum allocation available under paragraph (a).

259.83 POSTADOPTION SERVICES.

Subd. 3. **Identifying information.** In adoptive placements made on and after August 1, 1982, the agency responsible for or supervising the placement shall obtain from the birth parents named on the original birth record an affidavit attesting to the following:

(a) that the birth parent has been informed of the right of the adopted person at the age specified in section 259.89 to request from the agency the name, last known address, birthdate and birthplace of the birth parents named on the adopted person's original birth record;

(b) that each birth parent may file in the agency record an affidavit objecting to the release of any or all of the information listed in clause (a) about that birth parent, and that parent only, to the adopted person;

(c) that if the birth parent does not file an affidavit objecting to release of information before the adopted person reaches the age specified in section 259.89, the agency will provide the adopted person with the information upon request;

(d) that notwithstanding the filing of an affidavit, the adopted person may petition the court according to section 259.61 for release of identifying information about a birth parent;

(e) that the birth parent shall then have the opportunity to present evidence to the court that nondisclosure of identifying information is of greater benefit to the birth parent than disclosure to the adopted person; and

(f) that any objection filed by the birth parent shall become invalid when withdrawn by the birth parent or when the birth parent dies. Upon receipt of a death record for the birth parent, the agency shall release the identifying information to the adopted person if requested.

259.89 ACCESS TO ORIGINAL BIRTH RECORD INFORMATION.

Subd. 2. **Search.** Within six months after receiving notice of the request of the adopted person, the commissioner of human services' agent or a licensed child-placing agency shall make complete and reasonable efforts to notify each parent identified on the original birth record of the adopted person. The commissioner, the commissioner's agents, and licensed child-placing agencies may charge a reasonable fee to the adopted person for the cost of making a search

pursuant to this subdivision. Every licensed child-placing agency in the state shall cooperate with the commissioner of human services in efforts to notify an identified parent. All communications under this subdivision are confidential pursuant to section 13.02, subdivision 3.

For purposes of this subdivision, "notify" means a personal and confidential contact with the birth parents named on the original birth record of the adopted person. The contact shall be by an employee or agent of the licensed child-placing agency which processed the pertinent adoption or some other licensed child-placing agency designated by the commissioner of human services when it is determined to be reasonable by the commissioner; otherwise contact shall be by mail or telephone. The contact shall be evidenced by filing with the commissioner of health an affidavit of notification executed by the person who notified each parent certifying that each parent was given the following information:

(1) the nature of the information requested by the adopted person;

(2) the date of the request of the adopted person;

(3) the right of the parent to file, within 30 days of receipt of the notice, an affidavit with the commissioner of health stating that the information on the original birth record should not be disclosed;

(4) the right of the parent to file a consent to disclosure with the commissioner of health at any time; and

(5) the effect of a failure of the parent to file either a consent to disclosure or an affidavit stating that the information on the original birth record should not be disclosed.

Subd. 3. **Failure to notify parent.** If the commissioner of human services certifies to the commissioner of health an inability to notify a parent identified on the original birth record within six months, and if neither identified parent has at any time filed an unrevoked consent to disclosure with the commissioner of health, the information may be disclosed as follows:

(a) If the person was adopted prior to August 1, 1977, the person may petition the appropriate court for disclosure of the original birth record pursuant to section 259.61, and the court shall grant the petition if, after consideration of the interests of all known persons involved, the court determines that disclosure of the information would be of greater benefit than nondisclosure.

(b) If the person was adopted on or after August 1, 1977, the commissioner of health shall release the requested information to the adopted person.

If either parent identified on the birth record has at any time filed with the commissioner of health an unrevoked affidavit stating that the information on the original birth record should not be disclosed, the commissioner of health shall not disclose the information to the adopted person until the affidavit is revoked by the filing of a consent to disclosure by that parent.

Subd. 4. **Release of information after notice.** If, within six months, the commissioner of human services' agent or licensed child-placing agency documents to the commissioner of health notification of each parent identified on the original birth record pursuant to subdivision 2, the commissioner of health shall disclose the information requested by the adopted person 31 days after the date of the latest notice to either parent. This disclosure will occur if, at any time during the 31 days both of the parents identified on the original birth record have filed a consent to disclosure with the commissioner of health and neither consent to disclosure has been revoked by the subsequent filing by a parent of an affidavit stating that the information should not be disclosed. If only one parent has filed a consent to disclosure and the consent has not been revoked, the commissioner of health shall disclose, to the adopted person, original birth record information on the consenting parent only.

327.14 DEFINITIONS.

Subd. 5. **Primary license.** "Primary license" means the initial license issued to the first person, firm or corporation to establish and maintain, conduct or operate a manufactured home park or recreational camping area at any one location.

Subd. 6. **Annual license.** "Annual license" means a renewal license issued to the person, firm or corporation operating a previously licensed manufactured home park or recreational camping area.